S. HRG. 103–1069

MEDICAL MALPRACTICE REFORM

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Medical Malpractice Reform: S.Hrg.... RING

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SUBCOMMITTEE ON
COURTS AND ADMINISTRATIVE PRACTICE
OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

A HEARING TO DETERMINE WHETHER CONGRESS SHOULD FEDERALIZE A LAW IN THE HEALTH CARE PACKAGE ON MEDICAL MALPRACTICE REFORM

MAY 24, 1994

Serial No. J–103–56

Printed for the use of the Committee on the Judiciary

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MEDICAL MALPRACTICE REFORM

TUESDAY, MAY 24, 1994

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
SUBCOMMITTEE ON COURTS AND ADMINISTRATIVE PRACTICE,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in room SD–226, Dirksen Senate Office Building, Hon. Howell Heflin (chairman of the Subcommittee), presiding.

Present: Senators Grassley, and Hatch.

OPENING STATEMENT OF HON. HOWELL HEFLIN, A U.S. SENATOR FROM THE STATE OF ALABAMA

Senator HEFLIN. The hearing will come to order.

I would like to welcome the distinguished panel of witnesses today who have travelled from afar and at some inconvenience to their daily schedules to share with the Judiciary Committee some of their views on the issues relating to medical malpractice. Particularly and especially this committee is considering the desirability of whether or not Congress, as part of an overall health care package which is currently being drafted, should in some way federalize an area of the law which has traditionally been reserved to the States to handle.

We are all aware of the controversy surrounding this matter. There are those who feel that medical costs have soared out of control due to their perceptions that medical malpractice litigation is a major culprit. From the viewpoint of patients and those who represent the victims of malpractice, on the other hand, there is a concern that many who are injured are undercompensated or denied access to justice altogether.

I think there is little doubt that we have one of the best health care systems in the world, consisting of dedicated medical professionals whom I know wish to provide the highest quality care for their patients. I am a product of that dedication and expertise and am deeply appreciative of those who cared for me during my illness last year.

However, it is undeniable that health care costs are rising dramatically, and that is why Congress is now looking at options to make the system more efficient and cost-effective while at the same time ensuring that the American people receive the best care that the medical profession and its allied services can deliver. It is in the Nation's interest that these goals must be achieved.

The purpose of this hearing is to examine these and other issues to see if there is a need to achieve an appropriate balance between

those who are injured and those who provide health care services to the American public. Notwithstanding the objections of some of my colleagues on other committees, the Judiciary Committee has a clear right and responsibility to examine this area of health care reform, and on behalf of my colleagues I particularly welcome you and invite your testimony before the Committee.

We will include statements by Senators Hatch and Thurmond in the record.

[The prepared statements of Senators Orrin G. Hatch and Strom Thurmond follow:]

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

MR. CHAIRMAN: I am pleased that the Courts subcommittee is holding this hearing today. As you may know, this issue will be discussed in the Labor Committee markup, which is currently ongoing, and in other forums as well. I have a keen interest in this subject. As a former trial attorney, I tried numerous malpractice cases in the courts of Utah, and I represented both sides of the issue. And, as a senator who is concerned about the costs of regulation on business, especially as those costs affect the cost of health care, I am interested in finding ways to reduce those costs in a responsible way. There are a number of such legal issues we should address in health care reform.

Both malpractice and antitrust are forms of costly regulation of the health care market which add to the cost of providing health care services. Unlike most regulation, however, the regulation in these areas is left largely to the courts, where decisionmaking is incremental, often unpredictable, and always expensive. The costs of losing are exceptionally high. Malpractice awards in the millions of dollars are commonplace, and antitrust suits threaten triple damage awards. The costs of winning can also be high. The unpredictability and inconsistency of outcomes only add to the costs of doing business in health care markets—costs which are passed on to consumers in one form or another.

Furthermore, serious questions have been raised about the deterrence value of the litigation-base malpractice system. Critics of the system argue that very often the wrong plaintiffs are suing the wrong doctors, thus undermining the effectiveness of the tort system to weed out bad actors.

We can improve the system for all parties. I believe we should allow states to experiment with no-fault systems, practice guidelines, and other creative ways of reducing the costs of malpractice. In Utah, a number of providers are collaborating in an experiment in a pure no-fault plan in which a patient is paid a predetermined amount upon a showing that he or she had a bad result from medical treatment. The notion of fault would be completely dispensed with, eliminating any need for litigation costs.

We should encourage such experimentation. As the states gain experience with such no-fault experiments, the nation can learn whether such a system would reduce the overall costs of medical malpractice.

There are other system reforms we should explore. We can encourage early offers and non-litigious settlement of many claims by allowing either the provider or the patient to invoke a non-court process to settle an injured patient's economic damages. Such a system could expedite payments without costly legal wrangling about fault, causation and damages and provide greater certainty to patients, providers, and payers. But such a system should allow truly egregious cases to proceed to an appropriately tailored conclusion in alternative dispute systems or in the courts.

Other reforms, such as elimination of the collateral source rule and capping at a reasonable amount the more subjective types of damages, could help reduce the cost of malpractice insurance and defensive medicine. And, directing the judge, rather than the jury, to determine the amount of punitive damages could help rationalize the process, providing greater consistency and predictability to the system, which can enhance the quality control aspects as well.

Mr. Chairman, I look forward to the presentations and the discussion today. I believe this is an area where Congress can make significant contributions to reducing unnecessary costs that burden our health care system. Reasonable change in these areas would go a long way to encouraging the kinds of cost-savings the American people want and that the American health care system can provide.

PREPARED STATEMENT OF SENATOR STROM THURMOND

MR. CHAIRMAN: The hearing this morning focuses on the issue of medical malpractice. This is a complicated issue in which there are important interests to be balanced and upheld on both sides. On one hand, it is very important to see that patients who suffer from medical malpractice are compensated both fairly and quickly. It is also important for our medical system to have effective mechanisms to deter improper or incompetent medical care in order to minimize the amount of medical malpractice.

On the other hand, we must work to hold down the costs of medical care by closely examining all factors that are involved, and to encourage a malpractice system that is as fair and efficient as possible. Physicians and other medical providers should exercise their judgment based on what is best for their patients, not what will reduce baseless malpractice claims. Every unnecessary medical procedure wastes scarce medical dollars which our Nation cannot afford.

It seems clear that there is much room for improvement in our current malpractice system. The system must continue to provide adequate redress to the victims of malpractice, but it could be improved by resolving cases more quickly. While punitive damages will continue to play an important role in sanctioning outrageous conduct, it may make sense to consider steps to ensure that punitive damages are rationally related to reasonable goals and do not act as a lottery in which a few victims become instant multi-millionaires. Many other significant issues are being discussed:

- Use of alternative dispute resolution,
- Limits on non-economic damages,
- Limits on attorneys' fees,
- Limits on duplicative recoveries under the collateral source rule,
- And uniform statutes of limitations, among other matters.

Care must be taken to properly balance the interests involved in each of these issues and to analyze whether some of them are best left to the States to resolve. In particular, it is important to determine whether the proposed changes will limit the practice of "defensive" medicine in which procedures and tests are undertaken only for the purpose of minimizing the chance of malpractice claims. Medical procedures should be used only when it benefits the patient and not out of fear of legal claims. Each of these unneeded procedures increases the cost of medical care. These are wasted dollars which can better be used for medical care for those who need it.

In conclusion, Mr. Chairman, I want to welcome each of the witnesses and to thank them for their time in preparing and appearing before the Committee this morning on this important issue.

Senator HEFLIN. Our first witness is Cindy Lebow, representing the Department of Justice.

Ms. Lebow?

STATEMENT OF CYNTHIA C. LEBOW, SENIOR COUNSEL FOR POLICY, CIVIL DIVISION, U.S. DEPARTMENT OF JUSTICE

Ms. LEBOW. Thank you, Senator Heflin, and I would be remiss this morning if I did not say to you that it is a particular honor and privilege for me to be on this side of the podium here this morning.

I am pleased to be here to discuss the administration's proposals relating to the Health Security Act and medical malpractice reform. Every member of this administration stands ready to assist you and your colleagues in every way possible so that we may realize the prompt enactment of this historic legislation and fulfillment of the promise of affordable health care for all Americans.

In discussing possible reforms to our Medical Malpractice System, it is important to acknowledge the genuine emotions which surround this issue. From the standpoint of patients and those who represent the victims of malpractice, there is deep concern that

many who are wrongfully injured are undercompensated or denied access to justice altogether.

In the swirl of statistics offered up to prove one argument or another, it is easy to forget that bad things can and do happen to good people, leaving lifetime impairment, disfigurement, pain, infertility, and other real human miseries. At the same time, it is imperative that we recognize the frustration that doctors and other health care providers experience when faced with the excessive expense and delays of our Civil Justice System. Many doctors say they live with the constant fear of lawsuits which could harm their professional reputations, threaten their ability to practice medicine, and jeopardize their own and their family's financial security. Physicians view the malpractice system as haphazard, unpredictable and personally traumatic. No legal theory or statistic can diminish these concerns.

While the costs are hard to quantify, we do know that doctors practice "defensive medicine," which at least in part is related to malpractice litigation. Such practices have contributed to the soaring costs of our national health care bills, adding as much as $10 to $30 billion annually. The difficulty is in discerning the practice of "good medicine" from profitmaking fee-for-service arrangements from unnecessary procedures or tests performed merely to reduce the risk of litigation.

The President's proposal attempts to address the problems with the current system, while recognizing that medical malpractice litigation is a fundamental aspect of basic State tort law and jurisprudence. We know that virtually every State has adopted specific malpractice reforms since the liability insurance crises of the 1970's and 1980's. Each of those reforms has been tailored to the unique circumstances of the respective State Court and Civil Justice System involved.

We strongly believe that medical malpractice cases should continue to be litigated primarily in the State courts and that medical malpractice reform should respect the fundamental nature of State practice and procedure.

One of the frustrations about this whole issue is the lack of good empirical data to guide our deliberations. For a problem of this importance, the scarcity of research data is truly astonishing. We are hopeful that we might address the need for top-quality research through this legislation and a new emphasis on funding for civil justice research.

The President's proposal provides two new mechanisms for a more sensible and cost-effective approach to resolving medical malpractice disputes. First, it encourages consumers and providers to settle malpractice claims outside of court. Every health plan will be required to have in place at least one alternative dispute resolution mechanism, such as arbitration or medication, and every claim against a doctor or other provider must first be referred for ADR before it can be litigated. Although ADR is not binding—meaning that consumers have the right to go to court—it is mandatory.

Second, the Health Security Act provides that the National Practitioner Data Bank will make available to the public the names of practitioners who have a pattern of malpractice sanctions. Currently, malpractice payout and sanctions are reported to the Data

Bank and are made available to State licensing authorities but are not available to the general public.

For the first time, the names of licensed health care practitioners with repeated numbers of malpractice sanctions will be available to the consumers of health care services.

The Health Security Act also contains certain reforms to discourage the filing of frivolous lawsuits and to provide fair, uniform national rules for malpractice awards.

First, the Act limits the amount of a lawyer's fee to no more than one-third of the amount recovered in a malpractice case. Second, before a lawyer or plaintiff can file a malpractice lawsuit, he or she must first consult a qualified medical specialist and file an affidavit and written report prepared by the specialist, declaring that a reasonable and meritorious claim has been stated.

Third, double recoveries are eliminated by abolishing the collateral source rule in both Federal and State medical malpractice cases.

And fourth, the proposal allows either party to request that an award be paid periodically rather than in a lump sum.

One of the issues that has been hotly debated is a cap on damages in malpractice cases. Many urge that a limit be placed on noneconomic damages such as pain and suffering. We have examined that issue in detail. It was decided not to recommend caps on damages, and let me explain briefly why.

First, we have designed a series of changes intended to address specific problems with the malpractice system. If we address the problems of frivolous lawsuits, encourage early and realistic dispute resolution, and bar double recoveries, there is no reason to place arbitrary limits on damages.

Second, studies have shown, and it is obvious, that those affected by damages are those claimants who have been most severely injured. It is those individuals who need the award the most to compensate for the losses they have suffered and to get on with their lives with some degree of dignity and hope.

And finally, the States have enacted various limits on damages, and a few States have even held a cap on damages to be unconstitutional under their own State constitutions. It would disrupt those State initiatives to impose limits at the Federal level.

The Health Security Act attempts to strike a balance between the needs of those who are injured and those working diligently to provide high-quality health care. This is a controversial area, with some compelling arguments on all sides. We have attempted to select remedies that will effectively restrain the costs of defensive medicine and assure the delivery of quality health care to all Americans, while keeping intact the principles of fundamental federalism and fairness that characterize our tort law system.

I appreciate this opportunity to discuss our views, and I look forward to working with the members of the committee in the spirit of friendship and cooperation which has always characterized its work.

Senator GRASSLEY. Thank you.

Senator Grassley, do you have an opening statement?

Senator GRASSLEY. No, Mr. Chairman; just questions.

Senator HEFLIN. Ms. Lebow, I gather that the Clinton administration in its formulation considered some things—and you have mentioned that in effect you rejected the idea of caps on non-economic damages.

Ms. LEBOW. That is correct.

Senator HEFLIN. And you rejected the concept of punitive damages as they would apply to medical malpractice, including the proposal that if the FDA had approved them—that was rejected. You also rejected the concept of the several liability; you rejected the idea from a Federal basis of statutes of limitation at the Federal level; and you rejected the concept of the loser pays the attorney's fees, the English rule.

Now, as I understand it from the administration—you were nodding your head, so for the record, I reckon that meant that it was an affirmative answer to all of that.

Ms. LEBOW. That is correct.

Senator HEFLIN. Now, in the alternative dispute resolution mechanism, as I understand it, you would have an agency or a review board which would establish ADR procedures, but they would be prescribed, and each insurance company or each health plan would adopt one or the other, and it would be put contractually in their policy or in their program. Is that right?

Ms. LEBOW. Well, it is anticipated that each health plan would have an ADR system, that the National Health Board would review and issue regulations regarding these types of plans. There could be a variety of possibilities, and each plan could adopt one or more, and they would be available within the plan; that is correct.

Senator HEFLIN. As I understand it, you would go through that procedure, and is there any judicial review of the details of what they adopt in the fine print that is put into a plan as to the alternative dispute resolution?

Ms. LEBOW. I suppose judicial review would come into effect in two ways. First of all, there would inevitably be some kind of opportunity to review the regulations by the National Health Board which would govern this area generally; but then each individual State——

Senator HEFLIN. How would you have judicial review of that—would you give a citizen's suit to that?

Ms. LEBOW. I do not think that was contemplated in the legislation, but it is contemplated that the issuance of these regulations would be subject to the Administrative Procedures Act, presumably subject to the notice and comment provisions and so on, and that there might be some challenge to those regulations. It is not impossible to imagine that.

Senator HEFLIN. But if in the fine print in a policy, there are variances or additions, how could you have a review of that to see whether or not there was compliance with that particular system that had been approved by that Board?

Ms. LEBOW. I think then the review reverts back to the State courts, and there would be an opportunity for the State courts to review the various plans and to review the operation, implementation, and how it actually would work with respect to individual claimants.

Senator HEFLIN. For some people, there is some danger of wording, interpretation, additions as to compliance with a plan, as I see it; there is a problem dealing with that.

Also, as I understand it, the alternative dispute resolution mechanisms does not apply—at least, according to testimony that I have read for witnesses today, the manufacturers and other people who may be involved, it says that it does not apply to prescription drugs, medical devices, providers of blood tissue, and products. In other words, the alternative dispute resolution system would apply to the doctors and the hospitals, but not to drugs, medical devices, providers of blood tissue——

Ms. LEBOW. That is correct.

Senator HEFLIN. So you would have a situation in which you would have alternative dispute resolution applying to the doctors and the hospitals, but on the other hand, for the others, it would not apply.

Ms. LEBOW. Well, Senator Heflin, we attempted in developing this legislation to address really the most important problems as we saw it with respect to the Malpractice System. One is the cost of defensive medicine and what that adds to our total health care bill, and also the concern about the costs and delays of litigation in this area. Medical malpractice litigation tends to be quite local in nature, and actually, the number of cases involving products and medical devices and so on are relatively rare. So usually, you have the local doctor, the hospital, the nurse and so on. And we wanted to address those issues.

Product liability legislation is really a separate matter. There is legislation pending in the House and the Senate to deal with those issues. So that is really a separate matter and does not impact the issues that we were trying to address in this case.

With respect to ADR, there are, of course, a multitude of ADR opportunities now in the Federal courts; some mandatory in certain districts; Civil Justice Reform Act plans are implementing a variety of techniques in the Federal courts where the cases are brought there; and similar experimentation and really general adoption of those kinds of procedures is going on in the State courts as well.

So it would be possible if there were a product liability case that it might be subject to some kind of ADR independently with respect to the Court System where the case is brought. But we were attempting to deal with resolving these disputes between patients and doctors. Many times, people are hopeful of restoring that relationship, wanting to continue in that patient-doctor relationship and trying to resolve these kinds of disputes as quickly and as cost-effectively as we could.

Senator HEFLIN. Well, under the Federal Rules of Civil Procedure, all parties can bring suits arising out of the same instances and things combined, and you would not have separate suits on product liability. So I am just trying to see how it coalesces and comes together relative to how it might be handled in a lawsuit. It presents some problems under the existing practices, unless you change the Federal Rules of Civil Procedure substantially.

Senator GRASSLEY. Could I add something on that very same point? You started out by talking about ADR, but it seems to me like we would have the situation where a lawyer, to get around the

new procedure, ADR included, all he would have to do is include a medical supplier in the lawsuit, and all of a sudden, then, everything we are passing in the President's reform proposal would not apply, right, if they did include it, and it seems to me that in a lot of instances, it would be very easy to include, and so you preclude the use and whatever limits there are in the President's reform.

Ms. LEBOW. Senator, I do not think that ordinarily product manufacturers would be included in this kind of litigation if there were no basis for doing that. You are talking about procedures, provision of care, failure to provide care—where is the instance, actually, where you are talking about bringing in some kind of product involved in a medical malpractice case in the first place?

Obviously, you can never keep people from suing, but we are trying to, again, resolve these disputes between the patients, the doctors, the hospitals, and the immediate health care providers in a way that would expeditiously resolve the disputes, provide some additional access to justice for people with smaller claims, where those claims have traditionally been shut out of the Judicial System because of the cost. And the product liability aspect of this would be handled as other ordinary litigation.

Senator HEFLIN. In regard to the failure of arbitration—of course, you have got all sorts of alternative dispute resolution, mediation, and other things, too—but one that is frequently discussed is the question of court-annexed arbitration. There are constitutional issues that arise in these if there are impediments to a right of trial by jury or be construed as being an impediment to access to justice and to the Justice System.

Under the proposal, if you take a de novo trial, say, from arbitration, and you end up getting less, are there any proposals in the Clinton proposal that the loser would have to pay the cost of the arbitration or anything like that?

Ms. LEBOW. No, Senator Heflin. We do not have any direct proposals like that.

Senator HEFLIN. So in regards to the cost of the arbitration and arbitrator's fees and so on, who would be paying for that? Is that a Government cost, or would it be a cost on the health plan that called for it?

Ms. LEBOW. Well, again, you are looking at the ADR proposed in the Health Security Act being primarily conducted within the health plan, and that would be up to the specific plan, possibly in conformance with regulations that might be drafted by the National Health Board, as to how those costs would be borne.

There is also, obviously, the option of court-annexed multidoor courthouse approach, which—I know we have worked on other legislation—has been very successful and is being looked at very seriously so that there might be options for a court-annexed ADR procedure that might be appropriate here as well.

Senator HEFLIN. There have been some discussions as to the matter where the administration bill provides that a claimant must submit an affidavit from a qualified specialist as a reasonable and meritorious cause for the filing of the malpractice action. There have been some suggestions that the affidavit be that the claim is not a frivolous one, rather than it being a question of the affidavit and the expert attesting to a meritorious cause relative to the

bringing. And there may be constitutional issues that arise relative to that. Was it considered that the affidavit should be as to the fact that it was not frivolous, rather than in effect being meritorious, which is somewhat an invasion of the province of the jury for their determination?

Ms. LEBOW. The intention of this provision is to get at the frivolous lawsuits, so that you have a qualified medical specialist with expertise in the same area in which the injury or the claim occurs, looking at this claim and determining that there is some merit to bringing the lawsuit.

I understand your concern about that qualified medical specialist in any sense making a legal judgment about the merits or probable cause or whatever it might be about the cause of the injury. And any concerns that you might have on that, we would be happy to work with you and see if there is language that would be appropriate to address that concern.

Senator HEFLIN. Senator Grassley?

Senator GRASSLEY. Mr. Chairman, there are only two points I would bring up. One, you already brought up, and I would just add to that—and for Ms. Lebow's benefit to know my view, I think I probably expressed it when I asked my question, but I just think that it should apply to all people involved in the delivery of medicine, and I think, for reasons beyond the one that I gave, that it is going to be possible for people to include manufacturers in their lawsuits and get around whatever effect or ineffective reforms the President is proposing.

The second issue deals with the collateral source rule. I have some concerns about changing it. If it is changed—and I recognize that several other reform proposals on the Hill also change the collateral source rule—it means that employers and insurers will effectively be subsidizing the delivery of negligent medical care. On the other hand, it is a way to keep costs down to tell the victim of malpractice to use all sources of compensation before the lawsuit kicks in. But shouldn't those responsible for malpractice be held completely accountable, is my question to you. Another way of saying it is why should others absorb the costs of someone else's negligence.

Ms. LEBOW. Senator Grassley, as you mentioned, there are various formulations of collateral source rule reforms. We picked one, which is essentially a bar to double recoveries, believing that that was an effective means of actually reducing the overall calculation of damages in a medical malpractice case. There are other formulations which deal with collateral source as an evidentiary question from both sides, whether evidence of insurance coverage can be introduced, and so on. It is a matter of debate with all of this, really, and again, we would be happy to work with you if there are other formulations of this that you would like to see if we could work with you, we would be delighted to work with you.

Senator GRASSLEY. Thank you.

Thank you, Mr. Chairman.

Senator HEFLIN. On the collateral source rule, though, in the overall health care, if you take an individual who is unemployed, and pays his premiums, or he pays whatever fees under the health plan, which include his hospital bills and doctor bills, and he also

takes out the policy that would pay him some moneys relative to it, maybe medigap, plus others could be loss of wages and things of that sort, under the collateral source rule, in effect, because he purchased some sort of policy to pay it, it would go to the benefit of the defendant in a lawsuit under that source.

Ms. LEBOW. Senator, under our formulation, there would be a bar to recovery from the defendant or the defendant's insurance company of moneys that otherwise were available from collateral sources. The plaintiff or the claimant would clearly be collecting from the insurance. If they had wage protection insurance or disability insurance or whatever, they would be collecting that insurance that in fact they may have paid for, but there would not be double recovery from the defendant.

Senator HEFLIN. Well, as I understand the way it is written—and I may be mistaken—if I have an insurance policy that pays for my hospital bills as a result of the hospitalization that occurred as a result of the malpractice, and I pay for it, that can be introduced as a collateral source to reduce the amount of damages that I would recover from the defendant.

Ms. LEBOW. That is correct.

Senator HEFLIN. So in effect I would be paying for something that—it strikes me that there certainly ought to be exceptions relative to that, as well as others.

Ms. LEBOW. I am aware of the fact that people are concerned about the payment of premiums. There are some other formulations where at least the premiums that were paid may be discounted, and we would be happy to work with you as this moves forward.

Senator HEFLIN. You have come forth with a limited number of federalized provisions, and you are basically going to leave it to the States on the majority of the laws pertaining to malpractice. But you do invade, and you do start federalizing this area of the laws.

Ms. LEBOW. Senator, we tried to pick very selectively some areas that really deal more with the process than with the substantive tort laws, and we tried as much as possible to leave State procedure intact.

On the other hand, we recognize that there is this problem of defensive medicine. It is costing our Health Care System several, perhaps many billions of dollars a year. There are the frustrations with the system. And so we devised a package of proposals very selectively that could get at what we felt was the heart of this problem. Otherwise, we believe that State tort law and procedure, and the common law, is something in this area which really should remain intact.

Senator HEFLIN. I have read some reports on defensive medicine, and of course, this is a concern. The studies relative to overall cost—the CBO study shows that less than one percent of the overall cost to the health system is malpractice, but there is an argument that doctors practice defensive medicine. And the counter argument is that, regardless, as long as doctors can be sued—it would not make any difference if you had everything that the insurance companies and the doctors and the lawyers had in the law—the fact that they could be sued would mean that they would continue to practice defensive medicine; that actually, tort reform

does not get at the root cause. The root cause of defensive medicine is the fact that you could be sued. And there is a lot of psychology in the idea that you can be sued.

Did you all look into any aspect of whether or not what you recommend will in effect reduce the cost of defensive medicine?

Ms. LEBOW. Senator, as I said, this is unfortunately an area of our Civil Justice System that has not been researched terribly thoroughly. The Office of Technology Assessment is attempting to complete a study of defensive medicine. I think everyone is hopeful on all sides of this argument that they will provide some enlightenment. I think they anticipate having some publication of their study in the next couple of months.

We know that defensive medicine occurs, and some of it relates to the fear of litigation; some of it relates to just good medicine, being a careful practitioner; and some of it relates to fee-for-service arrangements where, for example, a doctor is referring a patient for an x-ray or a test of some kind, and they may have some financial interest in the lab or the x-ray facility, or they may just be able to, in a fee-for-service health care system, obtain profit from charging for that service. So it is hard to distinguish, but we know that there is out there more than just anecdote, more than just stories by doctors. We know that there is a certain amount of cost in the system which does relate to that super-cautiousness and that eye out for litigation, and that is what we are really trying to get at.

It is a hard dollar to measure, and there have been a lot of figures tossed around. The AMA estimates around $15 million. I think there is another fairly credible study that estimates around $25 billion. So that the numbers out there can vary widely. Some people have even tossed much larger figures around. But it is something which we know is there to some extent, and we were trying in a direct and selective way to get at this problem.

Senator HEFLIN. Thank you.

Senator GRASSLEY. Can I ask a question, Mr. Chairman?

Senator HEFLIN. Yes.

Senator GRASSLEY. This is just a little bit unrelated, but as far as fraud in medical malpractice, does your department have any problems with the use of qui tam?

Ms. LEBOW. Senator Grassley, I am going to refer you to our other folks in the Justice Department who are working on health care fraud and related qui tam questions. I will be glad to put you in touch with them.

Senator GRASSLEY. Well, then, as long as you are going to refer me to them, would you also ask them where the letter is that they were going to give me on the constitutionality of qui tam? Is it somewhere in the bureaucracy at Justice, or is it over in the bureaucracy of OMB?

Ms. LEBOW. I think I can find those people, and I will make an effort to remind them that they owe you a letter.

Senator GRASSLEY. Thank you.

Thank you, Mr. Chairman.

Senator HEFLIN. Thank you.

[The prepared statement of Cynthia C. Lebow follows:]

PREPARED STATEMENT OF CYNTHIA C. LEBOW

I am pleased to be here this morning to discuss the Health Security Act and the Administration's proposals relating to medical malpractice reform. As issues are aired and the debate becomes focused, every member of this Administration stands ready and willing to assist you and your colleagues in every way possible, so that we may realize the prompt enactment of this historic legislation by Congress and fulfillment of the promise of affordable health care for all Americans.

The President's health care reform plan is the most detailed and comprehensive health care proposal ever offered. The President has committed his views to legislation and my testimony today is part of a continuing dialogue on those views.

In discussing possible reforms to our medical malpractice system, it is important to acknowledge the genuine emotions which surround this issue. From the standpoint of patients and those who represent the victims of malpractice, there is deep concern that many who are wrongfully injured are undercompensated or denied access to justice altogether. In the swirl of statistics offered up to prove one argument or another, it is easy to forget that bad things can and do happen to good people, leaving lifetime impairment, disfigurement, pain, infertility or other real human miseries. At the same time, it is imperative that we recognize the frustration that doctors and other health care providers experience when faced with the excessive expense and delays of our civil justice system. Many doctors, particularly those who practice high-risk specialties such as surgery or obstetrics, say they live with the constant fear of lawsuits which could harm their professional reputations, threaten their ability to practice medicine, and jeopardize their own and their family's financial security. Physicians view the malpractice system as haphazard, unpredictable, and personally traumatic. No legal theory or statistic can diminish these concerns.

There is little empirical evidence that the malpractice system deters substandard care or actually promotes the practice of quality medicine. We do know, however, that doctors practice "defensive medicine" which, at least in part, is related to malpractice litigation. While the costs are hard to quantify, we know that such practices have contributed to the soaring costs of our national health care bill, estimated to be as much as $10 billion to $30 billion annually. The difficulty is in discerning the practice of "good medicine" from profitmaking fee-for-service arrangements from unnecessary procedures or tests performed merely to reduce the risk of litigation. While researchers tackle this difficult assignment, however, we must act now to reduce health care costs, and that means addressing the problems of our medical malpractice system.

The President's proposal attempts to address the problems with the current malpractice system, while recognizing that medical malpractice litigation is a fundamental aspect of basic state tort law and jurisprudence. We know that virtually every state has adopted specific malpractice reforms since the malpractice liability insurance crisis of the 1970's and 1980's. Each of those reforms has been tailored to the unique circumstances of the respective state court and civil justice system involved. We strongly believe that medical malpractice cases should continue to be litigated primarily in the state courts and that medical malpractice reform should respect the fundamental nature of state practice and procedure.

One of the frustrations about this whole issue is the lack of good empirical data to guide our deliberations. For a problem of this importance, the scarcity of reliable research data is astonishing. While we know a little about the effect of certain tort reforms on the pricing of malpractice insurance, we know virtually nothing, for example, about the impact on the size of verdicts, the trend in case settlements, or the effect on access to justice. We are hopeful that we might address the need for top-quality empirical research through this legislation and a new emphasis on funding for civil justice research.

The President's proposal provides two new mechanisms for a more sensible and cost-effective approach to resolving medical malpractice disputes. First, it encourages consumers and providers to settle malpractice claims outside of court. Every health plan will be required to develop and have in place at least one alternative dispute resolution mechanism, such as arbitration or mediation, and every claim against a doctor or other provider must first be referred for ADR before it can be litigated. Although ADR is not binding, meaning that consumers dissatisfied with the outcome can go to court, it is mandatory. Attempting to settle malpractice claims before they get to court has rewards for both patients and providers. Parties suffering real injuries will be compensated sooner and claimants with smaller claims will have increased access to a dispute resolution mechanism, avoiding the costs of extended litigation. Both sides may be spared the substantial stress of full-scale litigation. This arrangement will alert plan administrators to providers with

a track record of claims against them, and physicians may be saved the expense and distraction of defending meritless claims in court.

Second, the Health Security Act provides that the National Practitioner Data Bank will make available to the public the names of practitioners who have a pattern of malpractice payouts or sanctions. Under the Health Care Quality Improvement Act, malpractice payouts and sanctions are reported to the National Practitioner Data Bank and are made available to states or licensing authorities, but not to the general public.

For the first time, the names of licensed health care practitioners with repeated numbers of malpractice payouts or sanctions will be available to the public. Combined with the quality measures in the proposal, the public can make more informed choices about the practitioners they choose. Dr. Troyen Brennen, of Harvard Medical School, recently stated that we are not getting sufficient prevention and discipline out of the tort system, and a representative of the medical community recently testified that the identification of incompetent and unethical practitioners was a critical objective of health care reform. We believe that broad public access to the Data Bank will significantly advance this goal.

The Health Security Act also contains certain proposed reforms to discourage the filing of frivolous lawsuits and to provide fair, uniform national rules for malpractice awards.

First, the proposed Act limits the amount of a lawyer's fee to no more than one-third of the amount recovered in a malpractice case. However, states may impose lower limits. Although this proposal has been challenged as unfair to plaintiffs' trial lawyers, it is a change which has already been implemented in some form in many states. In fact, the Federal Tort Claims Act, under which medical malpractice suits are brought against federally-employed health care providers, establishes even lower attorneys' fee limits.

Second, under the Administration's proposal, before a lawyer can file a medical malpractice lawsuit, he or she must first consult a qualified medical specialist, and prepare an affidavit including a written report by the medical specialist. The written report must contain the specialist's determination that the specialist has reviewed the medical records, and believes that a "reasonable and meritorious" claim has been stated. Courts can impose sanctions against a plaintiff or attorney for affidavits submitted without reasonable cause.

Third, double recoveries are eliminated by abolishing the collateral source rule in both federal and state medical malpractice cases. The proposal reduces the amount of recovery by any amount recovered from another source, such as government benefits or private insurance. Again, this is simple fairness. If a health plan already provides for the health care coverage needed by an injured patient, there is no reason for a malpractice award to include this amount.

Fourth, the proposal allows either party to request that an award be paid periodically rather than in a lump sum. The judge would determine the schedule based on the needs of the injured party. This proposal, which is consistent with the recommendations of the National Conference of Commissioners on Uniform State Laws, is important for both injured parties and defendants so that funds will be available to compensate people at the time they need the money.

Over the past months, we have examined many different options. I know that distinguished Members of the Committee may have different ways of addressing the same problems we have identified. Striking the proper balance of competing concerns is not an easy task. There are no simple solutions. There are strongly held views on all sides. We hope to continue to discuss with you how best to accomplish our common goal.

One of the issues that has been hotly debated is consideration of a cap on damages in malpractice cases. Many urge that a limit be placed on non-economic damages, such as pain and suffering.

We have examined that issue in detail, and heard every opinion. It was decided not to recommend caps on damages, and let me explain briefly why that decision was made. First, we have designed a series of changes intended to address specific problems with the malpractice system. If we address the problems of frivolous lawsuits, encourage early and realistic dispute resolution, and bar double recoveries, there is no reason to place arbitrary limits on damages.

Second, studies have shown and it is obvious that those affected by caps on damages are those claimants who have been most severely injured. It is those individuals who need the money the most to compensate for the losses they have suffered and to get on with their lives with some degree of dignity and hope. No one wants to tell persons who have been severely injured through the negligence of others that they will not get fair compensation because there is some arbitrary limit, and that they are simply out of luck.

Third, the states have enacted various limits on damages, and a few states have even held a cap on damages to be unconstitutional under their respective state Constitutions. It would disrupt those state initiatives to impose limits at the federal level. The states vary widely in their rules. For example, California has a cap on non-economic damages of $250,000, while Indiana has an overall limit on economic and non-economic damages of $750,000.

The Health Security Act attempts to strike a balance between the needs of those who are injured and those working diligently to provide high quality health care. We believe we have done that. We recognize that this is a controversial area, with some compelling arguments on all sides. We have attempted to select remedies that will effectively restrain the costs of defensive medicine and assure the delivery of quality health care to all Americans, while keeping intact the principles of fundamental federalism and fairness that characterize our tort law system.

Let me also add that the problems of the medical malpractice system exemplify many of the difficulties confronting our civil justice system at both the state and federal levels. The Justice Department has undertaken a major access to justice study, aimed at reducing the costs and delays of civil litigation, increasing access to our justice system for all litigants, and restoring public confidence in a system which is fundamental to the rule of law. I am hopeful that we will soon be able to announce some bold and innovative proposals that will address the problems inherent in medical malpractice and other kinds of civil litigation.

I appreciate the opportunity to discuss our views and I look forward to working with all the Members of the Committee in the spirit of friendship and comity which characterizes its work as we move ahead in our historic effort to guarantee health security for all Americans.

Senator HEFLIN. Next is a panel consisting of Philip Corboy on behalf of the American Bar Association; Paul Ginsburg, Executive Director of the Physician Payment Review Commission; Dr. John Niles on behalf of the Health Care Liability Alliance; Mr. Victor Schwartz, of Crowell & Moring; and Laura Wittkin, on behalf of the National Center for Patients' Rights.

We will limit the testimony to 5 minutes, and all of your written statements will be made part of the record. If you wish to supplement it, we will keep the record open where supplemental statements can be added.

I believe Ms. Wittkin is starting off.

PANEL CONSISTING OF LAURA WITTKIN, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR PATIENTS' RIGHTS; VICTOR E. SCHWARTZ, CROWELL & MORING; DR. JOHN H. NILES, ON BEHALF OF HEALTH CARE LIABILITY ALLIANCE; PAUL B. GINSBURG, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION; AND PHILIP H. CORBOY, ON BEHALF OF THE AMERICAN BAR ASSOCIATION

STATEMENT OF LAURA WITTKIN

Ms. WITTKIN. Good morning. I am Laura Wittkin, and I am the executive director of the National Center for Patients' Rights, which is a medical malpractice victims' and patients' rights advocacy and support group. I am also a survivor of malpractice.

I would like to thank you for inviting me to testify today about the impact malpractice has on our Health Care System. It is crucial issue, yet a forgotten one, in this health care debate.

Medical malpractice is one of the leading public health epidemics our Nation faces today. It is the third leading cause of preventable death, killing one hospital patient every 6 minutes in this country.

It is alarming how a problem of this magnitude has been ignored by each and every administration, while the plight of its victims

have been reduced to malicious stereotypes promoted by the medical industry.

I would like to briefly examine the malpractice issue from three perspectives today—the emotional impact, its myths and realities, and the administration's response to this epidemic.

As a victim of malpractice, I am left with a permanent handicap and a constant reminder of what happens when the public is unprotected from dangerous and incompetent doctors. My case was tired in California under MICRA, the Medical Injury Compensation Reform Act. So I have personally experienced the dehumanizing effects of regressive tort reform, and that is precisely the framework on which the Clinton administration proposals are based.

At the Center for Patients' Rights, I spend most of my day dealing with an avalanche of calls from people who have been harmed by poor care, looking for help and support, and I think above all, accountability.

It was suggested that I provide you with some examples of stories that I hear, but frankly, I do not know where to begin. Do I talk about the risks that patients face in a managed care setting of being misdiagnosed? Or, do I tell you about how many mothers contact our group who have had children killed simply because doctors did not want to take the time or spend the money to do a proper review and diagnostic workup on those children?

To ask you to imagine yourselves in the shoes of these people I think is too cruel a request. But you must be convinced in some way that 100,000 deaths a year and over 300,000 serious injuries are not just numbers. They are your neighbors, your friends, your families, and your constituents. They are people whom you are here to represent and protect.

The myths about malpractice are outrageous, but let me give you some facts to set the record straight, all of which are backed up by renowned empirical studies.

Ninety percent of victims never bring lawsuits. Dangerous doctors already get a free ride in this country. Taxpayers pay more than $60 billion a year to provide services and care for people who cannot get into the tort system. States that have adopted tort reform similar to what the Clinton plan is proposing have realized none of the so-called benefits that the administration is suggesting.

According to the Office of Technology Assessment—something you heard about in the previous testimony—my organization and some others were briefed on that report, and they could not find any runaway defensive medicine practices. In fact, they were very critical of the AMA study, of the Lewin study on defensive medicine as being unreliable and unrealistic. They also said that most practices and most tests that are done are tests that have benefit to the patient and that if you were to reform the tort system today, you might reduce malpractice premiums, and you may make doctors feel a little less anxious, but you are not going to do anything to cut down on defensive medicine spending.

Successful frivolous suits by defendants outnumber supposed frivolous lawsuits by plaintiffs by 12 to one in this country. For some reason, though, the administration has ignored these facts, and instead, they have proposed amendments and legislation that

will victimize consumers and do nothing to improve the quality of health care.

For example, eliminating the collateral source rule will reduce the value of the case, making it much more difficult for victims to bring suits, and it will create a hidden health care tax, frankly, on employers and on all taxpayers, who will be forced to pick up the bill for all the collateral source benefits.

Requiring periodic payments also reduces the value of the case and lets the wrongdoer get off cheap by purchasing an annuity for a fraction of the award. It shackles victims to an endless bureaucratic system, and it deprives them of a full award.

Practice guidelines are totally offensive because they may only be introduced as evidence in any case at the discretion of the defendant, while plaintiffs would be unable to use a doctor's failure as evidence against the doctor in that case.

And the idea of imposing caps on noneconomic damages in addition to all of these other horrendous proposals is unthinkable. All victims would be hurt by such arbitrary limits, but the poor and the elderly, who have significantly less economic losses and who rarely sue, and are far more dependent on the contingency fee process, would be virtually locked out of that system.

Nobody is going to argue about the urgent need to reform our Health Care System, but I think we need reform that is based on sound public policy, not political expediency. I have provided the panel with a list of recommendations, and I would be happy to talk about them later.

Thank you.

Senator HEFLIN. Thank you.

[Laura Wittkin submitted the following materials:]

PREPARED STATEMENT OF LAURA WITTKIN

Good morning, my name is Laura Wittkin. I am the Executive Director of the National Center for Patients' Rights, a medical malpractice victims' and patients' rights advocacy and support group. I am also a survivor of medical malpractice. Thank you for inviting me to testify about the very real impact medical malpractice has on our health care system. It is an issue of paramount importance to the safety and well-being of all Americans, yet one which has been all but forgotten in the overall health care debate.

Medical malpractice is one of the leading public health epidemics our nation faces today. It is the third leading cause of preventable death, second only to those deaths associated with cigarette smoking and alcohol abuse. And while this may not be a statistic the AMA will admit to, medical malpractice is a devastating problem to all Americans and it needs our immediate attention.

It is alarming that a problem of this magnitude can be ignored by this and every other administration to date. Instead of attacking the problem head-on, they have all chosen, instead, to turn a blind eye to this epidemic and the plight of its millions of victims.

Thanks to a highly effective medical industry campaign which maliciously and falsely stereotypes malpractice victims as greedy, conniving parasites feeding off of the system by persecuting "powerless" doctors for financial gain, the rights of victims and of all medical consumers in this country have been dealt a crushing blow.

We must move beyond the rhetoric of rich and powerful interest groups and rely on the wealth of empirical studies that show a out-of-control medical system which promotes inferior and substandard care. That system is responsible for the deaths and injuries of nearly a half million people a year. And we must also address the catastrophic fiscal impact that such substandard care has on our nation's health care system as a whole.

I would like to examine the malpractice issue from three different perspectives. The first, is the emotional impact of this epidemic. The second, is the disparity be-

tween the myths and realities of the medical malpractice system. And the third, is the Administration's response to the growing epidemic of medical malpractice.

I. EMOTIONAL IMPACT OF MEDICAL MALPRACTICE

As a victim of medical malpractice, I am left with a lifelong handicap and the constantly painful reminder of what happens when the public is left unprotected against incompetent and dangerous doctors.

My malpractice case was tried in California eight years ago under the Medical Injury Compensation Reform Act, otherwise known as MICRA. Under MICRA I experienced, firsthand, the cruel and dehumanizing effects of regressive tort reform which rewards the wrongdoer and punishes their victims by callously limiting their legal redress and compensation. Unfortunately, it is this anti-consumer Act which provides the framework for the Clinton Administration's liability reform proposals.

My own life-threatening experience with medical malpractice led me to form the National Center for Patients' Rights (CPR), the largest advocacy and support group of its kind, where most of my day is spent responding to the overwhelming flood of calls and letters we receive from medical malpractice victims and their loved ones who are desperately crying out for help, answers, understanding, compassion, and above all, accountability.

The families that reach out to our organization are trying valiantly, though often unsuccessfully, to cope with the senseless loss of a child, the untimely death of a spouse or parent, permanent crippling injuries or unbearable pain and suffering, which rob victims of their dignity and quality of life, and often leave entire households shattered in their wake.

In the last month, every network news show has aired a story on a different aspect of medical negligence and, unfortunately, they haven't even scratched the surface of this enormous problem. Someone suggested that I give you specific examples of the types of stories I hear, but I just don't know where to begin. Do I talk about the overwhelming problem of managed care and the alarming odds a patient in that type of setting faces of being misdiagnosed.

Or do I tell you about the many mothers who call me because their children were killed by doctors who just wouldn't listen to the very real symptoms the child was complaining of. Or, perhaps, I should recount the stories of the myriad of medical practitioners, be they doctors, nurses or lab technicians, who, one would think would be prepared for any and all emergencies, yet, find themselves pawns, just as all Americans are, when they become patients in our medical system.

All of the stories I hear are horrifying and heartbreaking and most typify the plight and human toll medical malpractice takes on us all. To even ask you to imagine yourselves in their shoes would be too cruel a request. But somehow you must be convinced that 100,000 deaths and 300,000 serious disabling injuries aren't just numbers * * * they are your neighbors, your friends, your families * * * they are your constituents, the people you are here to represent and protect.

You must understand that in the face of such true and sometimes interminable suffering, we have become sick and tired of hearing about how much doctors are the ones suffering from the threat of malpractice litigation. And we are tired of hearing how sleepless *their* nights are. No doctor's liability anxiety can ever begin to compare to the real life pain, loss or death suffered by hundreds of thousands of medical malpractice victims and their families in this country each and every day.

II. MEDICAL MALPRACTICE MYTH VERSUS REALITY

The MYTHS about the malpractice system, which have been carefully propagated by the medical industry and now embraced by the Clinton Administration, are simply outrageous and groundless:

> MYTH: The medical malpractice liability system is overwhelmed by excessive and frivolous lawsuits.
>
> MYTH: Lawsuits result in outrageous jury awards and excessive plaintiff attorney fees, and do not deter poor care.
>
> MYTH: The liability crisis and high premiums are responsible for decreased access to care, runaway health care spending, and defensive medicine practices.

Permit me to set the record straight with the following *facts* (most of which belie the medical lobbies "self-anointed" status as "victims" of the medical malpractice system):

> FACT: The current medical malpractice system actually *prevents* the majority of victims (90 percent) from bringing lawsuits, and most victims who receive awards are *undercompensated* based on the severity of their injuries.

FACT: The liability system as it exists today, already gives negligent practitioners and providers a free ride on the backs of the American taxpayers. It's the taxpayers who foot the *sixty billion dollar* bill each year to provide care and services to the hundreds of thousands of victims who have been locked out of the legal system. According to Dr. Troyen Brennan, co-author of the landmark Harvard Medical Practice Study, "this figure of $60 billion is larger than the combined estimates of the costs of medical malpractice premiums ($10 billion) and defensive medicine ($10–$20 billion)".

FACT: States which have adopted tort reforms similar to ones outlined in the Clinton Bill, have failed to realize any of the so-called benefits this Administration claims they have, such as: savings to the health care system, increased access to health care, more affordable care, or a reduction in "so-called" defensive medicine spending and "frivolous" lawsuits by plaintiffs. The Administration, nonetheless, insists on pushing the American people down this misguided path.

FACT: The malpractice liability system is not responsible for runaway "defensive medicine" practices. A soon to be released Study on Defensive Medicine and Medical Malpractice, by the Office of Technology Assessment (OTA) found that both the AMA and Lewin Studies on defensive medicine spending are inaccurate, unreliable and not based on empirically solid evidence. (Yet, these defensive medicine studies are still used as one of the primary justifications for national liability reform.)

OTA also found that physicians rarely perform tests that will not benefit patients, and that much of what is mistakenly characterized as "defensive medicine" practices is, in fact, sound medical practice. OTA concluded that while tort reform may lower premiums and a physician's anxiety, it will not effect the practice of defensive medicine.

These findings were echoed in an earlier Congressional Budget Office Report on Health Care Reform, which stated that even if medical malpractice liability were reformed, "much of the care that is commonly dubbed 'defensive medicine' would probably continue to be provided for reasons other than concerns about malpractice."

FACT: The tort system DOES deter poor practices. According to Dr. Troy Brennan of the Harvard Study team, recent empirical analysis done at the hospital level found that as liability claims increased per 1,000 discharges, the risk of negligent injury for patients decreased. To quote Dr. Brennan, "this is the first statistically significant evidence that there is a deterrent effect associated with malpractice litigation. It suggests that tort litigation, with all of its warts, nonetheless accomplishes the task for which it is primarily intended, that is the prevention of medical injury".

FACT: Successful frivolous *defenses* by doctors, lawyers and insurance companies FAR OUTNUMBER "possible" frivolous plaintiff's verdicts by a Staggering ratio of *12 to 1* according to a landmark study by the American College of Physicians, published in the Annals of Internal Medicine, November 1992. The study found that doctors currently win approximately 60 percent of *indefensible* cases at trial, compared to as few as 5 percent plaintiff wins in so-called defensible cases.

FACT: Victims of malpractice are forced to wait years for redress and compensation while insurance companies and defense attorneys, driven by their own financial self-interests, syphon off their profits through investment earnings and uncapped and outrageously high hourly defense fees for handling such cases—All of which are responsible for driving up the cost of the medical liability system.

FACT: The malpractice system is not at all biased against doctors, but is, in fact, remarkably lenient towards them. It is a system in which doctors do not lose malpractice cases they should win. And it is a system whose payouts to victims are not based on the whims of overly sympathetic jurors, but rather are consist with the extent of negligence and injury to the patient. (These findings based on the 1992 American College of Physicians Study on medical malpractice lawsuits of New Jersey).

III. THE CLINTON ADMINISTRATION'S RESPONSE TO THE MEDICAL MALPRACTICE EPIDEMIC

Despite the overwhelming evidence about the realities of the tort system, the Clinton Administration has, nonetheless, chosen to predicate its medical malpractice reform proposals on false premises.

When Ira Magaziner spoke about Health Care Reform at Citizen Action's National Conference in July of last year, he said the Administration would be basing medical malpractice reform on three KEY principles. They wanted to design a malpractice system which would:

1. Increase access to the tort system for people who are currently locked out.

2. Develop a national enforcement system for repeat malpractice offenders. Ironically, Mr. Magaziner even went so far as to state that the Administration believed that doctors who commit malpractice *twice* should permanently lose their right to practice medicine in this country.

3. And last but not least, to ensure that victims receive the awards that they deserve both in non-economic and economic damages, while limiting all attorneys fees (*defense* fees, as well, as plaintiff fees).

But the Administration delivered just the opposite of what Mr. Magaziner promised. Almost all of the liability reform proposals in the Clinton Plan harm, punish and discriminate against medical consumers and victims of malpractice, and do absolutely nothing to safeguard the delivery of quality health care in this country.

Nowhere is the power of the medical and insurance lobbies more evident than in the text of this Bill. Although President Clinton begins by admitting that the cost of medical malpractice accounts for less than 2 percent of our nation's health care bill. Somehow, from this "less than two percent threat" comes legislation which virtually annihilates patients' recourse in the tort system, reduces their financial resources to deal with the harms effects of medical malpractice * * * and allows negligent doctors to sleep better at night.

FOUR of these proposals are particularly troubling:

1. Elimination of collateral source rule

This reform requires that all victims' awards be *automatically reduced* by any past or future health care, social service, employment or other benefits they may be eligible for. However, there is no way to guarantee that all of a victim's medical needs will be met in a specific health care plan, or that they will, automatically in the future qualify for and receive other collateral benefits. Also, the reducing of awards by collateral sources, instead of allowing for subrogation, devalues a case, making it less economically viable for attorneys to take.

The net result of this proposal is the further victimization of patients harmed by substandard care and a *hidden health care tax* on employers and all taxpayers, because they are the ones who would be forced to pick-up the bill for all collateral source benefits.

2. Periodic payment of awards

This reform states that, instead of paying out the entire award upfront, either party may request that the award be paid out over a period of many years or a lifetime. This proposal is yet another example of the cruel re-victimization of patients harmed by poor care, because only *DEFENDANTS* (and their insurance carriers) would ever make this request.

It allows the wrongdoer to purchase an annuity for a *fraction* of cost of the award (about 113 the cost), invest much of that money, and dole it out to the victim bit-by-bit over the course of the victim's lifetime.

This effectively shackles malpractice victims and their families to an endless bureaucratic system and deprives them of their award. And, if the victim dies BEFORE all of the award is paid out, the unpaid medical and economic losses go back into insurance company coffers, NOT to the victim's family.

Periodic payments also reduce the overall value of cases, again, creating a financial disincentive for attorneys to take those cases on.

3. Alternative dispute resolution mechanisms (ADR)

This reform would require that all malpractice claimants first submit to some form of non-binding arbitration, mediation or early settlement process PRIOR to proceeding with a malpractice action. Because there is NO incentive to resolve the case, this proposal would simply drag out malpractice cases, cause further harm to the victims, and increase the cost of litigation. The only effective ADR mechanism which would, in fact, expedite cases and reduce the cost of litigation (but which is, unfortunately, NOT part of the Clinton Plan), would be binding arbitration for low-end cases, at the discretion of the plaintiff ONLY.

4. Practice guidelines as a defense

This reform would establish a pilot program to test the use of practice guidelines as a DEFENSE in medical malpractice cases. This proposal is one-sided and grossly

unfair, because evidence about compliance with guidelines could only be introduced at the discretion of the DEFENDANT.

The defendant would be able to literally pick and choose those cases in which they wish to introduce evidence of compliance with practice guidelines, while the plaintiff would be prohibited from introducing evidence about the FAILURE to follow those *same* guidelines as grounds for medical malpractice.

This discriminatory proposal is particularly harmful to medical malpractice victims since, according to the Physician Payment Review Commission, practice guidelines are already being successfully used in malpractice cases, far more by PLAINTIFFS, than by Defendants. Under the Clinton Bill, this would no longer be the case.

CONCLUSION

This administration suffers from a *skewed* expression of outrage and misguided empathy over the emotional distress and inconvenience doctors feel when they are sued. A sentiment which is, frankly, incomprehensible in the face of our nation's growing medical malpractice epidemic. Their complete failure to acknowledge and resolve the endless, suffocating pain and devastation negligent doctors inflict on victims and their families, is unconscionable.

For us, the litmus test of whether the Clinton Administration is truly designing a health care system that is in the best interest of the American people, a system based on careful, thoughtful and honest research and analysis of the entire health delivery system, can be seen in the way they have handled the issue of medical malpractice.

We had hoped for strong leadership and progressive malpractice reform solutions which would protect the rights of innocent people harmed by medical negligence while improving the overall quality of care. Instead, what this administration has given us is simply a repackaging of the same morally bankrupt and fiscally irresponsible tort reform garbage the medical industry has been peddling for years.

Before becoming a physician, one must take an oath to do no harm and a vow to uphold the professional responsibly that defines the position. No one will argue about the urgent need to reform health care in this country. But, it must be a system based on sound public policy, not political expediency. In the final analysis it comes down to one simple question * * * Are we willing to pay for our medical care with our lives?

FEDERAL PRO-CONSUMER MEDICAL MALPRACTICE LIABILITY REFORM RECOMMENDATIONS

To improve the malpractice liability system and protect the rights of medical consumers and victims of malpractice, the National Center for Patients' Rights recommends the following:

(NOTE: Where applicable, these reforms are intended to pre-empt state law.)

1. A three-year Statute of limitations for the DISPOSITION of all malpractice cases (from date of filing).
2. Expedited handling of cases involving children and terminally ill patients.
3. Creation of a Small Claims Binding Arbitration Unit for cases under $100,000.
4. A cap on defense attorney fees.
5. Removal of limitations or caps on non-economic damage awards.
6. Full, lump sum payment of awards, unless otherwise requested by the plaintiff.
7. Reinstatement of the collateral source rule, along with the right to subrogation in all states which have eliminated that rule.
8. Opening the National Practitioners' Data Bank to the public, in its entirety. And creating an on-line inquiry system to allow easy access for consumers.
9. Closing the reporting loopholes in the National Practitioners Data Bank which currently allow doctors to remove their names from malpractice case settlements involving hospitals and managed care plans.
10. Outlawing secrecy agreements.
11. Mandating medical malpractice insurance coverage, (the minimum amount of coverage, to be determined) as a condition of licensure for all physicians.
12. Community-rating of malpractice premiums so that the costs are spread more equitably among the specialties.

13. A minimum 3½ year statute of limitation for filing malpractice lawsuits. That statute would be extended in cases where there has been continuous treatment, late discovery, suppression of information or criminal coverup. (This statute would not apply to minors.)
14. Mandatory audits for all medical malpractice insurance carriers (once every three years) so that premium rates can be appropriately adjusted. These audits would also be required PRIOR to any state granting premium increase requests.
15. Federal minimum standards for all State Medical Boards (see attached Federal Model prepared by CPR.)

MODEL FOR STATE MEDICAL BOARD MINIMUM STANDARDS

In order to improve physician discipline and protect the public from harm, the Federal government should enact the following minimum requirements for all state medical boards (in alphabetical order):

1. Board composition.—All Boards shall be composed of a majority of public members (*at least* 51 percent, preferably two-thirds). The Chairperson and Vice-Chair of the Board shall be public members. The size of the Board shall be based on the state's physician population (to be determined). Physician Board members shall be appointed by the Governor based solely on recommendations *not* nominations from a variety of recognized medical and non-medical sources (to be determined). Board members shall serve a term of no longer than 3 years (with one consecutive term).

2. Consent agreements.—Boards shall prohibit plea bargains or consent agreements unless the physician agrees to plead guilty to the most serious allegation. Boards shall prohibit such agreements in negligence and incompetence-related cases unless the physician agrees to plead guilty to the most serious allegation *and* surrender his or her license.

3. Consumer protection unit.—Boards shall create a special Consumer Protection Unit which will consist of consumer protection officers with medical or social work background to deal directly with victim complainants. And all victim complainants shall be granted statutory immunity from liability, for libel, defamation, etc.

4. Disciplinary hearings.—Board disciplinary hearings shall be open to the public, and all hearings shall adhere to a specified time frame (to be determined).

5. Funding.—Boards shall be allotted *adequate* funding in order hire the caliber of investigators, prosecutors and support staff necessary to effectively oversee the profession (and may raise physician fees to do so). All physician licensure and registration fees, *and any reserves*, shall be dedicated for exclusive use by the medical board. These funds may not be touched by a state for ANY reason other than the prescribed ones.

6. Impaired physicians.—Boards shall establish an Impaired Physician Program (based on a model to be developed), and shall maintain jurisdiction over that program. Boards shall conduct an annual audit of the Impaired Physician Program and make the findings publicly available.

7. Informal actions.—Boards shall share information about informal actions, such as letters of warning, with other jurisdictions.

8. Investigators.—Boards shall upgrade the salary and qualifications for complaint investigators (⅔'s of whom shall have medical background).

9. Licensure.—Boards shall be responsible for both licensure and discipline of physicians. Grounds for denial of licensure shall include the following:

(a) Any act or conduct which would constitute grounds for medical misconduct in the state in which the physician is applying.

(b) Any disciplinary action taken in another jurisdiction, which would constitute grounds for medical misconduct in the state in which the physician is applying.

(c) Any PENDING disciplinary investigation or action in another jurisdiction.

(d) Loss of hospital privileges in another jurisdiction.

(e) Malpractice lawsuits in another jurisdiction indicating that the doctor presents a risk.

10. License restorations.—Boards shall require that any physician who has lost a license (as a result of surrender or revocation), wait a *minimum* of 5 years before applying for reinstatement of license, and must provide proof of on-going medical and remedial training (the parameters for which are to be determined).

11. Malpractice insurance.—Boards shall require doctors to carry malpractice insurance as a condition of licensure. The amount of coverage shall be determined by the specialty. Physicians who perform surgery, but DO NOT have hospital privileges shall carry the same minimum coverage as physicians with hospital privileges.

12. Malpractice data unit.—Boards shall create a Malpractice Data Unit. This unit will be responsible for collecting all malpractice data statewide, and reviewing all malpractice claims to determine if they warrant further investigation for possible medical misconduct. This unit will also be responsible for developing a system that will *flag* physicians with an abnormally high number of malpractice claims or payouts. Doctors who fit these "outlier" profiles (which should be based on the size and scope of a doctor's practice, the specialty, and other risk-adjusted factors) would be subject to an automatic full-scale investigation.

13. Mandatory reporting.—Boards shall require mandatory reporting of violations or dangerous practices by all licensees (including self-reporting by the licensee committing violation), courts, hospitals (staff and administration), all other health care providers (including HMO's clinics, etc.), liability insurance carriers, state and local medical societies and associations, state and local professional societies, other state agencies, PRO's, other health care professions, and federal agencies. All states shall impose severe civil penalties for failure to report.

Boards shall assure confidentiality to those reporting to the Board in good faith on possible violations. Board members, Board staff, individuals, and organizations required by law to report shall be granted immunity from prosecution and suit.

Liability carriers and self-insured entities must report all claims, and all payments including the dollar amount.

14. Misconduct definitions.—Boards shall adopt uniform definitions of medical misconduct (based on a compilation of the *strongest* current state medical misconduct definitions).

15. Out-Of-State actions.—Boards *shall not* conduct a new hearing on any action taken by another jurisdiction, but shall only determine the appropriate disciplinary sanction to be imposed based on that out-of-state action. That sanction shall, at a minimum, be equivalent to the original sanction imposed.

16. Permanent loss of license.—Boards shall permanently revoke the license of any physician convicted of medicaid/medicare fraud, fraudulent billing, child sex abuse, other sex abuse, murder (and other criminal acts, to be determined); or found guilty of falsifying or, in any way, altering medical records to conceal malpractice or other wrongdoing.

17. Physician Discipline Oversight Panel.—Boards shall establish a Discipline Oversight Panel to assess the physician discipline system. The panel shall consist of seven members appointed by the governor and may include no more than two physicians and one attorney. The panel members shall serve as individuals not as representatives of any organization, institution, agency or group. Panel members shall not participate in or review pending matters, but will review final determinations to assess the quality of work and whether the decisions are in the public interest. The panel shall assess the overall goals and objectives of physician discipline; how well the goals are being met; and whether and to what degree the process serves to minimize or deter medical misconduct. The panel may consult with medical and specialty societies, consumer organizations, other governmental organizations, state organizations, federal organizations and other states in its analysis and deliberations.

This panel shall also handle *complainant appeals* of cases dismissed by the Board without action.

18. Physician self-referrals.—Boards shall prohibit the practice which allows treating doctors to refer patients to clinics, labs, or other health care-related facilities or services in which that doctor, or his or her immediate family, has a financial interest. Any violation shall constitute grounds for medical misconduct. Any physician who currently self-refers shall have one year to comply with the statute.

19. Public information and outreach.—Boards shall have a public information officer responsible for organizing consumer and physician outreach and education programs, to include: development of a quarterly newsletter, information brochures, public serve announcements, and other outreach efforts to community groups, organizations, agencies, etc.

Boards shall set-up (and adequately staff) toll-free hotlines for consumer complaints and physician background checks. Anyone calling to check on a doctor shall *automatically* be entitled to the following physician "profile" information: date physician was first licensed; educational background; registration status; hospital affiliations; other states in which the doctor holds a license; the number of closed complaints against the physician (regardless of whether or not an action was taken); any formal charges pending against the physician; any disciplinary action taken

against the physician's license (including a brief explanation about the basis for the action). This profile may be mailed to consumers upon request. After the federal government enacts legislation to open up the National Practitioners' Data Bank, callers will also *automatically* be given the Data Bank's toll-free number.

Boards shall issue an annual report made available to the public, media, legislature and other state officials. The report should contain information on licensure, including: number of applications received, licenses granted, licensure hearings, denials, temporary licenses, etc. The report shall also contain disciplinary information, including: number of complaints received (plus the source, status, category), number of actions taken, category of action; types of penalties; aggregate information about informal actions taken, etc. (Full list of items, to be developed.)

20. Recredentialing.—Boards shall require doctors to be recredentialed every 5 years as a condition of licensure. Doctors who have been involved in lawsuits or other disciplinary actions during any interim period, would be required to undergo a "clinical" performance evaluation as part of their recredentialing.

Doctors who practice *exclusively* in private office settings would also be required to undergo clinical performance evaluations and patient chart reviews for recredentialing.

21. Standard of Proof—Boards shall require that the standard of proof in disciplinary actions be a *preponderance of the evidence* ONLY. No other standard will be acceptable.

22. Subpoena power.—Boards shall have full subpoena power.

23. Summary suspensions.—Boards shall have the power to issue summary suspensions which will run until a hearing can be promptly scheduled.

Senator HEFLIN: Dr. Ginsburg?

STATEMENT OF PAUL B. GINSBURG

Mr. GINSBURG. Thank you, Mr. Chairman.

The Physician Payment Review Commission was created in 1986 to advise the Congress on issues related to physician payment in the Medicare Program. Its 1989 proposal for physician payment reform was enacted in that year and implemented in 1992.

The Commission's mandate was substantially broadened in 1990, and one of its specific charges was to advise on medical malpractice reform.

Although the Commission's membership includes physicians from various specialties and practice settings, 7 of its 13 members come from other backgrounds which include business, consumers, nursing, HMO's, and economics.

The Commission's proposals that are presented in this testimony have the support of all the members of the Commission.

The Medical Malpractice System needs to become more effective and efficient in limiting the rate of medical injuries and compensating injured patients. Reform should also address widespread concerns if the system promotes the practice of defensive medicine and impedes many efforts to improve the cost-effectiveness of care.

The Commission has outlined a malpractice system for the future that we should work toward, as well as some steps to improve the functioning of the current system. A future malpractice system would have two components—an efficient administrative system to compensate patients who experience medical injuries, and a complementary structure for monitoring, quality review, and design and implementation of measures to reduce the rate of injuries.

Separating decisions on compensation from review of quality of care would enable each to be accomplished by systems best suited to that purpose. This would permit compensation to be improved, while increasing physicians' confidence in judgments of their quality of care.

This new system cannot be implemented now because extensive developments and experimentation are needed for key components, but initial steps should be taken now. First, better data on medical injuries should be collected and employed to prevent injuries and improve the quality of care.

Second, binding alternative dispute resolution systems for compensating injured patients should be developed and tested. And finally, more reliable standards for compensation than negligence should be formulated.

To immediately improve the functioning of the current system, the Commission recommends the adoption of certain tort reforms. These include rationalizing damages awards by the adoption of reasonable schedules for noneconomic damages, and in the interim, limits may be employed; offset of awards for collateral source payments; periodic payment of large awards; and assignment of punitive damage awards to quality improvement activities.

Additional recommendations include schedules for attorneys' contingency fees, thresholds for joint and several liability, and reduction of statutes of limitations for minors to a reasonable period.

The evidence does not yet justify requiring the use of certificates of merit and enterprise liability.

Although tort reform will not solve all the problems of the malpractice system, they can make a significant contribution. Compensation would be come more consistent and predictable, and administrative costs would be reduced if the case is sufficiently compelling for a Federal mandate.

Much attention is being focused on how practice guidelines are likely to be treated in the malpractice system. The Commission believes it would be premature for the Federal Government to mandate that all States accord special legal status to practice guidelines. This conclusion is based in part on the empirical study sponsored by the Commission. The results of the study showed that practice guidelines are playing a modest but increasing role in litigation. Their effects seem positive overall.

For example, one-fourth of the plaintiffs' attorneys reported that in the past year, a practice guideline had influenced their decision not to take a case. The results of State experiments with according special legal status to practice guidelines should be assessed before proceeding further in this area.

Thank you.

Senator HEFLIN. Thank you.

[The prepared statement of Paul B. Ginsburg follows:]

PREPARED STATEMENT OF PAUL B. GINSBURG

The medical malpractice system needs to become more effective and efficient in limiting the rate of medical injuries and compensating injured patients. Reform should also address widespread concerns that the system promotes the practice of defensive medicine and impedes many efforts to improve the cost effectiveness of care.

To immediately improve the functioning of the current system, the Commission recommends the adoption of certain tort reforms. These include rationalizing damages awards by the adoption of reasonable schedules for noneconomic damages (interim limits may be employed until a schedule is adopted), offset of awards for collateral source payments, periodic payment of large awards, and assignment of punitive damages awards to quality improvement activities. Additional recommendations include schedules for attorneys' contingency fees, thresholds for joint and several li-

ability, and reduction of statutes of limitations for minors to a reasonable period. The evidence does not yet justify requiring the use of certificates of merit and enterprise liability.

Practice guidelines are playing a modest but increasing role in litigation. Their effects seem positive overall. The Commission believes it would be premature for the federal government to mandate that all states accord special legal status to practice guidelines.

To fully meet the goals of malpractice reform, the Commission has proposed development of a restructured malpractice system. This future system would have two components: an efficient administrative system to compensate patients who experience medical injuries, and a complementary structure for monitoring, quality review, and design and implementation of measures to reduce the rate of injuries. Steps should be taken now to craft this future system. First, better data on medical injuries should be collected and employed to prevent injuries and improve the quality of care. Malpractice data should not, however, be disclosed to the public at this time. Second, binding alternative dispute resolution systems for compensating injured patients should be developed and tested. Finally, more reliable standards for compensation than negligence should be formulated.

I am pleased to appear before this subcommittee on behalf of the Physician Payment Review Commission. The Commission was established by the Congress in 1986 to provide advice and recommendations on methods to reform payment to physicians under the Medicare program. The Commission's work helped pave the way for the Medicare physician payment reforms enacted in 1989 and implemented in 1992. The Congress subsequently expanded the Commission's mandate to include a wide range of health policy issues, including medical malpractice reform. The Commission submits a series of reports to the Congress each year, the most comprehensive being its annual report which you received on March 31.

During the past four years, the Commission has conducted an extensive analysis of the medical malpractice problem and explored a range of ideas for reform. It also commissioned the first empirical research to be conducted on the role of practice guidelines in malpractice litigation. The Commission appreciates the opportunity to summarize the results of its work on this topic. Additional details and supporting documentation can be found in a chapter on medical malpractice reform in our 1994 Annual Report to Congress.

The problems with the malpractice system have received widespread attention. Although medical care in the United States is generally of high quality, the incidence of preventable medical injury is greater than acceptable. Few patients who are negligently injured are compensated, and the awards are variable. The existing malpractice system promotes the practice of defensive medicine and impedes efforts to improve the cost effectiveness of care. Further, the system's inefficiency results in high administrative costs and long delays in claims resolution. The goals of reform are to address these deficiencies.

The Commission has formulated a set of recommendations that include specific tort reforms to improve immediately the functioning of the current system. In addition, the Commission has identified steps that should be taken in the near term to pave the way for more fundamental reform of the malpractice system in the future. Tort reforms are discussed first, followed by an analysis of the role of practice guidelines in malpractice litigation. A future malpractice system envisioned by the Commission is then described, along with recommendations for beginning work on the building blocks of this system. These include better systems to prevent medical injuries, administrative systems for handling malpractice claims, and alternative standards for the compensation of medical injuries.

TORT REFORMS

Tort reforms are changes in the legal rules governing malpractice lawsuits. The Commission recommends certain of these reforms to improve the functioning of the current system. They would make damage awards more consistent and predictable, speed the settlement of cases, direct more resources to compensate injured patients, and reduce the occurrence of inappropriate and excessive awards. While some versions of tort reforms have the potential to inappropriately disadvantage injured patients, the Commission has taken care to formulate its tort reform recommendations so as to improve the system's fairness overall.

Schedules for noneconomic damages

Reasonable schedules should be developed for noneconomic damages. Much of the unpredictability and inconsistency that characterize today's malpractice awards are because of noneconomic damages (i.e., pain and suffering), which account for about

50 percent of total payments. Reducing the subjectivity of noneconomic damages and eliminating the potential for unreasonably high awards would improve decisionmaking during the course of a lawsuit and promote settlement.

The schedules would set acceptable ranges for awards for carefully defined categories of injuries. Schedules would establish a different limit for each grade of injuries, which is preferable to a single absolute limit that may be too high for some injuries and too low for others. Until a schedule is developed, however, it may be necessary to adopt a single interim absolute limit on noneconomic damages.

Schedules for attorneys' contingency fees

The typical contingency fee paid to the claimant's attorney out of an award is about one-third of the recovery. A sliding-scale schedule for contingency fees would better approximate the fee to the work performed by the lawyer, so that more of a large award goes to the injured patient.

Modification of the collateral source rule

This reform would limit the potential for "double recoveries" by some plaintiffs and would improve the efficiency of the system. So-called collateral sources of payment, such as health or disability insurance, operate more efficiently than the malpractice system. Permitting these other payments to be subtracted from malpractice awards would allow a higher portion of malpractice premiums to be devoted to compensation and less to administrative costs.

Restrictions on joint and several liability

Thresholds should be adopted for the application of joint and several liability. In cases with more than one defendant, the doctrine of joint and several liability holds any defendant responsible for the full award if any other defendants cannot pay their shares apportioned by fault. Practitioners and entities with adequate insurance or resources to pay malpractice awards do not want to pay the full amount of an award when their contribution to fault is minor or negligible, and the potential for liability out of proportion to fault encourages defensive medicine. But limits on joint and several liability may come at the expense of adequately compensating injured patients. The Commission recommends that a balance be struck by adopting thresholds for the application of joint and several liability.

Periodic payments of large awards

More than half the states require that larger awards for future damages be paid in installments over time. The Commission recommends periodic payment for large awards. This would ensure that adequate resources are available to meet future needs.

Reductions in long statutes of limitation

Overly long statutes of limitation create uncertainty, delay, and expense in insuring against malpractice claims. Birth-related injuries are the principal source of problems. Eight years is a safe period to allow detection of perinatal injury, and shorter periods are defensible. States that have longer statutes of limitations for minors should be required to reduce them to eight years at most.

Punitive damages

Part or all of punitive damages awards should be diverted to quality improvement activities. Punitive damages, by definition, are not compensatory in nature. Their purpose is to deter others from similar conduct, thus protecting future patients from injury. This end would be furthered if the money from these awards were used directly for injury prevention or quality improvement activities.

OTHER PROPOSALS FOR TORT REFORMS

Some other proposed tort reforms have promise, but current knowledge of their effectiveness is not sufficient to justify that they be federally mandated. These include a certificate of merit requirement and a mandate for enterprise liability.

Certificate of merit

A certificate of merit is a requirement that an independent medical expert review the medical record and certify that a claim is worthy before a formal lawsuit can be filed. It is often difficult to judge at a case's inception whether it is likely to be successful because key information is not available in the medical record. If the requirements for determining merit are loosened to respond to this problem, it will simply add another step to the litigation process, consuming time and money. This may be a barrier to some meritorious claims being brought, particularly for low-income plaintiffs who would have to incur the additional costs of this initial evalua-

tion. If the certificate of merit requirement is too strict, some cases that eventually would be successful might be screened out simply because of incomplete information. Although the idea has promise, more needs to be learned about how to make certificate of merit programs work well before they are federally mandated.

Enterprise liability

Under enterprise liability, a health care organization assumes financial responsibility for all negligent injuries to patients under its care, thereby relieving individual practitioners of any personal tort liability for such injuries. This is thought to save administrative costs and to better focus efforts to prevent injuries. It is presently working well for hospitals owned and staffed by one organization. As vertical integration spreads through the delivery system, enterprise liability is likely to follow naturally for reasons of efficiency. Although the trend toward enterprise liability is encouraging, the Commission considers it unwise to impose enterprise liability on organizations and physicians that are not sufficiently integrated for the policy to work well: e.g., third-party indemnity payers and independent fee-for-service physicians.

THE ROLE OF PRACTICE GUIDELINES IN MALPRACTICE LITIGATION

Practice guidelines are a key element of the nation's efforts to improve the quality and cost-effectiveness of medical care. How guidelines are treated in the malpractice system has important implications for their success. Practice guidelines may help to improve the functioning of the malpractice system. This is because guidelines can make clear the applicable standard of care, which is a troublesome issue in many malpractice cases. They might lessen the need for expert testimony on the standard of care, thus avoiding a battle of the experts. Guidelines may appropriately increase the amount of malpractice litigation by helping make clear to injured patients, their lawyers, orjuries that a standard of care was breached, while reducing the number of meritless cases filed.

Several factors, however, might prevent practice guidelines from improving the functioning of the malpractice system. The topics on which guidelines are being developed probably are irrelevant to the circumstances leading to most malpractice claims. Guidelines might be construed to create a firm standard of care when one is neither intended nor appropriate. While practice guidelines could provide an important legal support for physicians and health care organizations that use them, their revision by the judicial system could render guidelines ineffective in helping to control costs and improve quality. Such revisions could take two forms: an explicit rejection of the content of the guideline, or a carving-out of exceptions that effectively vitiates it. In addition, increased litigation might result from questioning the validity of guidelines or the circumstances under which exceptions are warranted. In response to these concerns, some states, including Maine, have given practice guidelines special legal status to facilitate their use by defense attorneys, and thus encourage their use by physicians. No cases have been brought since these policies were enacted.

The Commission believes that the experience in these states should be assessed before the federal government would mandate that all states accord special legal status to practice guidelines. Particular attention should be paid to whether these actions have promoted or impeded the appropriate use of guidelines in litigation and in patient care. Until this information is obtained, it would be premature to proceed with a federal mandate. A recent study by the Commission, which I will describe in a moment, revealed nothing alarming about the current use of practice guidelines in malpractice litigation, so special legal protections may not be necessary. One would want to accord special status only to high-quality guidelines; the manner by which such guidelines are identified may itself confer the desired special weight in litigation. The asymmetry of some states' initiatives, in which only the defense can use practice guidelines, is problematic.

The commission's study of practice guidelines in malpractice litigation

Because little is known about the use of practice guidelines in malpractice litigation, the Commission engaged Harvard University researchers to conduct a study to provide empirical information on this topic. The study had three components. The first was a review of published judicial decisions that concern practice guidelines. The second was a review of malpractice claims files to determine how often guidelines were used in actual malpractice cases, and to discover the ways they were used. The last was a survey mailed to a large sample of plaintiffs' and defendants' lawyers.

Several conclusions can be drawn from this study (the findings are described in detail in the Commission's Annual Report to Congress 1994). Practice guidelines are

playing a modest but increasing role in malpractice litigation. About half of the malpractice attorneys surveyed had at least one case each year in which guidelines played a role, and a high proportion reported that the use of guidelines was increasing. Still, only 7 percent of the 259 claims reviewed from the malpractice insurers' files involved the use of guidelines. Obstetric guidelines are the ones most frequently being used, probably because they are among the oldest and best known to physicians and lawyers.

Guidelines are being introduced more often by plaintiff than by defense attorneys, possibly because guidelines may provide cheaper or stronger evidence of the standard of care than expert testimony. The use of guidelines by either side is usually, but not always, successful in malpractice litigation. In published judicial decisions, for example, plaintiffs won 17 of the 23 cases in which their lawyers used the practice guidelines, while in 6 of 9 cases a practice guideline was used successfully by the defense.

Guidelines helped lawyers, judges, and juries reach decisions. Of the attorneys representing plaintiffs, one-quarter stated that a guideline had influenced their decision not to take a case in the past year; one quarter of all the attorneys noted that a guideline had influenced their decision to drop or settle a case. One-quarter also said that a guideline had influenced the decision of a trier of fact (jury or judge) in at least one case during the preceding year. The lawyers did not report much change in the need for expert testimony.

Although the effects of guidelines on the litigation process are varied, overall they seem positive. Future monitoring and research are needed to assess whether guidelines are being used appropriately in court, including whether disputes about their applicability or content are troublesome. The results should inform how guidelines are derived and drafted.

DEVELOPING A FUTURE MALPRACTICE SYSTEM THAT WOULD BETTER ACHIEVE ITS GOALS

The tort reforms recommended by the Commission are essential to improve the existing malpractice system, but they are not sufficient to ameliorate all of its problems. Tort reform is unlikely, for example, to reduce substantially the practice of defensive medicine, improve the prevention of medical injuries, or compensate more of the negligently injured patients who are not compensated today. More fundamental changes are needed to accomplish these goals. These changes are embodied in a future malpractice system that the Commission has outlined.

The proposed system would have two components. One would be a fast, efficient administrative compensation mechanism that would provide adequate awards to patients who experience preventable medical injuries. The other would be a complementary system for monitoring, quality review, and design and implementation of measures to reduce the rate of injury. An important feature of the proposed system is that decisions about compensation and quality of care in individual cases would each be made by a process designed specifically for that purpose. Clear criteria for compensability and for damages awards would be established, whereas judgments about quality of care would be made in forums better suited to make those determinations.

These components could be developed in an evolutionary manner. To pave the way for this system of the future, the Commission's recommendations focus on:

- improving systems to prevent injuries,
- developing and using efficient alternative dispute resolution systems for compensating injured patients, and
- formulating and testing more reliable standards for compensation decisions.

Preventing medical injuries

A systematic approach to injury prevention is likely to be most effective in reducing the rate of injury. The federal government should support a variety of initiatives that are needed to put a systematic approach into action. Effective injury reduction programs require the collection and analysis of data, as well as the design and implementation of effective interventions. Better data are needed to help detect preventable injuries and determine their causes. Early warning systems and active surveillance are needed to detect as many preventable injuries as possible, not just those that result in claims. The basic epidemiology of medical injuries should be delineated. Coding systems should be developed to permit this more abstract information to be entered into computerized databases. Because many events need to be collected and analyzed to detect patterns of rare events, local databases must be compatible to permit merging. Health system reform may provide an opportunity for the development of standardized coding and databases.

Public disclosure of malpractice data.—One strategy that has been suggested to better protect patients from negligent injuries is to provide them with information about the malpractice experience of physicians and health plans. Consumers could be given access, for example, to the physician-specific information about malpractice payments contained in the National Practitioner Data Bank (NPDB), to which all malpractice payments made on behalf of physicians must be reported.

The Commission recommends against such disclosures at this time. The information would be of little help to the individual patient, and public disclosures would be likely to adversely affect the underlying processes that generate the information. There are reports that more physicians are refusing to settle cases in order to avoid being reported to the now-confidential NPDB. The incidence of defensive medicine—particularly the avoidance of risks by refusal to provide high-risk services—would likely be increased. The public would be better served if such information were used effectively by the quality assurance and oversight mechanisms of the profession and of state licensing boards.

Alternative dispute resolution systems

Significant improvement in how malpractice claims are processed can occur only outside the courtroom. The Commission believes that better alternative dispute resolution (ADR) systems need to be developed and tested, however, before all claims should be required to be resolved by ADR methods. Little is known about the efficacy of ADR in medical malpractice. The experience of some health plans with binding arbitration reportedly has been favorable, but at least one has discontinued arbitration because of a shortage of qualified arbitrators.

There are potential disadvantages to ADR. The quality of any ADR process depends heavily on the personnel involved. It is unlikely that enough high-quality ADR services would be available immediately if all medical malpractice cases had to use this technique. Finally, ADR systems may evoke counterproductive behavioral responses, which are difficult to predict in advance. For example, if final adjudicatory hearings are cheaper, easier, and faster than jury trials, more cases might proceed to such hearings, lengthening rather than shortening delays in compensation. Demonstrations and evaluations should be supported by the federal government to learn more about how ADR systems can best operate.

ADR must be binding to have a positive effect. Otherwise, it would merely impose additional delays and costs on an already slow and expensive litigation process. An ideal scenario would be the development of ADR systems advantageous to plaintiffs and defendants alike, so that both would voluntarily agree to using them and being bound by the result.

Alternative standards for compensation

The negligence standard does not appear to be a good guide to decision making by providers and juries. More reliable standards for liability could possibly be developed. Such standards must be tested for their reliability and their effects on the number and size of claims paid. One standard that has been proposed is no-fault, which would compensate patients whose injuries were caused by medical care, regardless of whether the care was substandard or not. The determination of eligibility for compensation would be simplified and made more reliable by dispensing with the need to determine the standard of care and whether it was breached. The principal fear raised by a no-fault system is that vastly larger numbers of injuries might become eligible for compensation. A no-fault standard should be tested first in a demonstration.

Another standard might be based on avoidability, to compensate patients for injuries that need not have occurred. Some errors in care are not negligent. For example, a mistake in considered professional judgement is often deemed not to be negligent. This standard would focus prevention efforts on the full range of preventable injuries, rather than just negligent ones. Fewer claims would be compensated than under no-fault. For example, a particular treatment may entail a known but unavoidable risk of serious injury or complication. Patients who experience an adverse outcome from that treatment would be compensated under a no-fault system, but not under a standard based on avoidability. This standard shares with no-fault the advantage of not conditioning compensation on a judgment about whether the care was substandard. Compensation for an injury would not itself mean that the care was substandard; that determination would need to be made through another mechanism better suited to that task. This could reduce inappropriate defensive medicine practices and improve providers' confidence in the system. It is probably easier to determine simply whether an injury was avoidable than whether failure to avoid was due to negligence, but there is no information on the reliability of a standard based on avoidability. Research is needed to develop and test such a standard.

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Senator HEFLIN: Dr. Niles?

STATEMENT OF DR. JOHN H. NILES

Dr. NILES. Good morning, Mr. Chairman and members of the Committee, and thank you for giving me the opportunity to testify regarding the importance of tort reform as a component of comprehensive health care reform legislation.

I am a private practitioner, a solo practitioner, and I am board-certified in obstetrics and gynecology, and located here in Washington, DC. I have been in practice for the past 24 years.

A detailed statement dealing with the technical aspects of my testimony has been supplied.

I want to emphasize two issues in my testimony which are access to care and fairness to health care providers. All the associations that I am currently a member of—the American Medical Association, the National Medical Association, the American College of Obstetricians and Gynecologists—have endorsed or supported comprehensive medical liability reform as described in the President's Health Security Act.

While the President's reform bill is the first good step, it does not go far enough. The most significant proposal missing in the President's Health Security Act is a cap on noneconomic damages. I support a cap of $250,000, which is the current limit imposed in California.

In the absence of a cap on noneconomic damages, tort reform would not be as effective a means of containing the cost of medical liability premiums in my particular specialty. The cap on noneconomic loss in California has provided containment of liability premiums in that State.

The President and the First Lady have indicated that a major health care reform goal is universal access to care in the United States. In particular, access to quality prenatal care is of critical importance. Adequate prenatal care requires highly trained and experienced practitioners and specialists and is of critical importance to the potentially high-risk population with the highest infant mortality that we see here in the United States.

The level of current malpractice premiums and the ever-present fear of malpractice suits is creating a critical shortage of physicians, particularly in my specialty of obstetrics. Studies by the National Academy of Sciences, the Southern Legislative Conference, and our own local District of Columbia Intergovernmental Relations Office have concluded that the availability of ob-gyn providers is decreasing and that this decrease has a disproportionate effect on availability of obstetrical care for poor women and Medicaid patients.

I will quote directly from the Southern Leadership Conference report released in 1990:

> Traditional tort reforms have been partly successful in some States in ensuring the availability of medical malpractice insurance and in limiting cost increases. Current tort reforms have not stemmed the exodus of obstetrical providers from the field, and some solution is needed to ensure that pregnant women have access to good medical care.

Dr. Charles Epps, dean of the Howard University College of Medicine, the institution that has trained the majority of African-Amer-

ican physicians in this country, has outlined the access problem here locally in the District of Columbia as it applies to minority populations. And just as an aside, Senator, the comment was made this morning that there are tort reforms in all States. The District of Columbia has no formal tort reform.

I will quote a few excerpts from Dr. Epps' statement.

An unprecedented 400 percent increase in medical malpractice premiums during the past 7 years has occurred in the District. This is driving away physicians, including those willing to practice in the neediest wards. Studies show that not a single neurosurgeon nor orthopedic surgeon has opened a solo practice in the District of Columbia in the past 5 years. In a November 1987 survey of the Medical Society of the District of Columbia, 83 percent of the responding ob-gyns said they would not accept Medicaid ob patients. The reason? They said they could not provide such service and carry the required malpractice insurance.

My personal opinion is that we need a national solution to this problem. Only by having the Federal Government set minimal standards will we be able to reverse the upward trend in medical malpractice premiums and help guarantee that all persons will have access to quality obstetric care.

I would also like the Committee to consider tort reform as an issue of fairness. The current hodge-podge of medical liability laws in different States is unfair to all physicians. For example, medical malpractice premiums are significantly lower in Maryland and Virginia than they are in the District of Columbia. There is no reason to penalize doctors who choose to practice in a jurisdiction with no reform.

I will give a personal example of that point. Currently, the statute of limitations for medical malpractice actions varies from State to State. In the District of Columbia, where there is no tort reform legislation, there is a statute of limitations of 21 years for birth-related cases. A month ago, I received a letter from a hospital medical records department indicating a law firm had requested records on a baby I delivered in December of 1973. As you can imagine, I do not keep records for 20 years. Luckily, the hospital where the baby was delivered maintained a copy of that particular record.

In this case, the delivery was uneventful, and there were no obvious problems. I am now faced with the prospect of a malpractice suit for an event that occurred over 20 years ago.

As a minority physician provider, I have special concerns. The ever-increasing cost of malpractice premiums, supplies and office overhead impact on my ability to continue to practice obstetrics in underserved communities. Many minority physicians earn less than nonminority doctors because they provide care to low-income patients, including Medicaid patients, which are reimbursed at a lower rate, but they will have to pay the same malpractice premiums and the same overhead expenses that their colleagues pay. There is less and less incentive for minority physicians to go into my field of specialty.

The Urban Institute published an article entitled, "Obstetrics and Malpractice" in the June 1991 issue of JAMA, the Journal of the American Medical Association. The article made the following statement:

American malpractice law has many weaknesses, as does all of liability law. Legal process leaves enormous discretion about medical standards and causation to

nonexperts. Legal standards are vague, even at formal trial, particularly on how jurors determine fault and extent of pain and suffering. Further, there is also no oversight of the informal negotiations in which lawyers and claim adjusters settle almost all cases. The process is not only time-consuming; it is also expensive, and results are often inconsistent across cases. To physicians, the position is arbitrary and lacks scientific legitimacy, which hurts the law's goal of deterring substandard care.

Legal processes also divorce medical quality monitoring and assurance. Problems are particularly acute for obstetricians. Malpractice fears and high premiums can contribute to excessive service such as unnecessary C-sections and diagnostic tests or insufficient service, such as physicians no longer assisting in births of babies, especially to mothers who are uninsured or only have Medicaid coverage.

No physician wants to protect bad doctors. That is why we support clinical guidelines and other risk management strategies that will help improve medical care. And I will submit after my testimony an example of practice guidelines that I just recently, with the chief of staff at Columbia Hospital for Women, developed practice guidelines for obstetrical and gyn patients, as an example. And a similar project is going on in Maine to use guidelines as a device in the use of reducing premiums.

I would urge Congress in their deliberations on health care reform legislation to please place in any legislation that is eventually agreed to strong tort reform so that physicians can continue to practice medicine.

Specially, I urge Congress to enact tort reform based upon the California model, which includes caps on noneconomic damages and other reforms that help provide a level playing field for physicians.

I just want to make one statement that is not in my prepared testimony. In the United States currently, it is safer to have a baby in this country than in any other country in the world, and yet our obstetricians are at risk for liability. Seventy percent of obstetricians in this country have been sued. These situations would not suggest that it is only poor physicians or poor doctors that are causing the problem. I would hope that Congress would look at this issue and provide a level playing field for physicians to continue to practice in this country.

Thank you, Mr. Chairman.

Senator HEFLIN. Thank you.

[Dr. John H. Niles submitted the following materials:]

PREPARED STATEMENT OF JOHN H. NILES

Summary

Dr. Niles has practiced obstetrics and gynecology in the District of Columbia for more than twenty years. During that time he has experienced, first-hand, the effects of a tort system that is out of control. In the last 15 years, medical malpractice premiums in the District of Columbia have risen 550 percent resulting in medical liability premiums of as much as $60,000 per year.

The exorbitant costs associated with high risk specialties, such as obstetrics, are forcing physicians to abandon high risk specialties or limit their practices to less risky procedures. Doctors are also practicing defensive medicine to protect themselves from medical liability suits.

This problem must be addressed at the national level. For example, in the District of Columbia where there is a very active plaintiff's bar, and where the city council has several practicing plaintiff's attorneys, there is virtually no chance that reforms will be implemented at the local level.

Dr. Niles is testifying on behalf of the Health Care Liability Alliance (HCLA) a coalition of health care providers, health service organizations, product manufac-

turer groups, and other individuals and organizations that believe that medical liability reform must be part of comprehensive health care reform.

The HCLA supports reforms such as a $250,000 cap on non-economic damages, mandatory non-binding alternative dispute resolution, statute of limitations reform and elimination of joint and several liability.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: My name is John H. Niles, MD. I am an obstetrician/gynecologist in private practice in the District of Columbia. Until April of this year I served as Chief of Staff at the Columbia Hospital for Women here in Washington, DC. I am also a former President of the Medical Society of the District of Columbia and a member of the National Medical Association, the American Medical Association and the American College of Obstetricians & Gynecologists. On behalf of the Health Care Liability Alliance and myself, I am pleased to have this opportunity to testify regarding the need for medical liability reform as a necessary component of comprehensive health system reform.

The Health Care Liability Alliance (HCLA) is a coalition of health care providers, insurers, health service organizations, and individuals who believe that our country's dysfunctional system for resolving health care liability disputes is a national problem that demands a national solution. HCLA members have come together with the common purpose of calling for the inclusion of health care liability reform in federal health care reform legislation (An HCLA membership list is attached as Appendix A).

As the *1994 Physician Payment Review Commission (PPRC) Annual Report to Congress* published earlier this month—and many reports before it—make clear, the current system for compensating patients who have been injured in the course of receiving health care services is broken and should be repaired at the national level. (The PPRC Report is attached as Appendix B.[1]) The system is inefficient and wasteful, contributes to problems with patient access to obstetric care and other specialty services, produces unfair and inconsistent outcomes, and benefits lawyers more than it does injured plaintiffs.

Unless changes are made in our liability laws, health care costs will continue to rise increase and access to health products and services will continue to be unnecessarily constrained. Medical malpractice premiums were the fastest growing component of physicians' practice costs in the 1980s. Driven by sharp increases in the frequency of claims and the average malpractice award in the early 1980s, malpractice premiums grew at twice the rate of medical inflation. Following a plateau in the growth cycle at the end of that decade, frequency and average award magnitude began to climb again in the early 1990s. Premiums have followed suit.

For example, malpractice premiums increased by 14 percent in New York in 1993, and the largest New York insurance carrier has applied to the state's Insurance Commission for a 19 percent increase in 1994. A new report from the Texas Medical Association (attached as Appendix C[2]) has declared eleven counties in that state to be "disaster areas" due to sharp increases in award frequency and average magnitude in recent years.

Members of the HCLA believe that liability reform should apply equally to all potential defendants in personal injury cases arising from the delivery of health care services. Physicians will continue to practice "defensive" medicine or be reluctant to provide treatment to patients in those areas of medicine that are plagued by lawsuits. Life-saving drugs and medical devices will be slow in emerging and will either cost more, or become completely unavailable. Health care costs will increase as managed care plans—increasingly targeted as the "deepest pocket" of all defendants—feel constrained to pay for unproven or experimental treatments rather than run the risk of multi-million dollar awards.

For these reasons, members of the HCLA believe that national health care reform will not be effective unless it includes broad-based liability reform applicable in all medical malpractice claims arising from the delivery of health care services. Reform should apply whether the defendants are physicians, nurses, hospitals, pharmaceutical and medical device makers and distributors, managed care organizations or others. Twenty years of experience in the states has produced valuable information upon which to craft federal policy. In particular, California's Medical Injury Com-

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[1] Retained in Committee files: *Physician Payment Review Commission Annual Report to Congress.*

[2] Retained in Committee files: *Medical Professional Liability, An Examination of Claims Frequency and Severity in Texas,* jointly prepared by Texas Medical Association and Tonn & Associates, February 1994.

pensation Reform Act (MJCRA), in place since 1975, has proven to be an effective model, and is the basis of the legislative package supported by all HCLA members.

DEFINING THE PROBLEM

The United States has the world's most expensive tort system. At 2.3 percent of Gross Domestic Product, U.S. tort costs are substantially higher than that of any country, according to surveys by the Tillinghast actuarial firm, and two and a half times the average of all developed countries. The U.S. tort system cost $132 billion in 1992. Between 1933 and 1991, U.S. tort costs rose by a factor of almost 400. By contrast, U.S. economic output (GNP) grew only one hundredfold over the same period. Thus, tort costs have grown almost four times faster than the U.S. economy over the past 58 years. (*Tort Cost Trends, An International Perspective,* Tillinghast 1992.)

In the District of Columbia where I practice, malpractice premiums for obstetricians have risen 550 percent in the last 15 years. I have paid as much as $60,000 for liability insurance, and there is no indication that the rates will decrease any time soon without comprehensive liability reform. My experience in Washington is in stark contrast to physicians in states where effective liability reform has been achieved. (A comparison of District of Columbia and California premiums is attached as Appendix D.[3])

Despite the magnitude of spending, our tort system functions very poorly in meeting its twin objectives of compensating victims and improving patient safety by deterring careless or wrongful behavior. No where is this truer than in what the RAND Corporation has accurately dubbed the "high stakes" world of medical liability and product liability litigation. (*Trends in Tort Litigation: The Story Behind the Statistics,* RAND R–3583–1CJ, 1987.) For many years this country has grappled with the growing inability of the civil justice system to resolve health care liability claims in a fair, timely and cost effective manner.

Health Care Liability: A Public Concern

Americans want reform and are frustrated by the failure of lawmakers in most states to take effective action. They increasingly look to the Congress for leadership.

Every recent poll has demonstrated that the American public strongly supports effective medical liability reform as a component of health system reform. According to a 1991 Gallup Poll, 77 percent of Americans think malpractice lawsuits and awards are an important reason for the rising costs in health care. The *Los Angeles Times* found that given seven possible reasons for expensive health care in this country, people are most likely to name malpractice suits. A 1992 survey shows that 44 percent of the public believes that only about half of the plaintiffs in civil liability lawsuits have just cause to file suit. A growing number—now a third of the population (34 percent)—say that the majority of civil liability lawsuits can't be justified.

Many jurors also feel lawsuits are abused. In interviews with 269 jurors in the Northeast, Valerie Hans, a professor at the University of Delaware, says she was struck by the jurors' spontaneous referrals to "frivolous lawsuits" and "litigation explosion." The jurors' attitudes showed in their verdicts. The jurors agreed or strongly agreed with the following statements:

> There are too many frivolous lawsuits today (83 percent); people are too quick to sue (81 percent); and the threat of lawsuits is so prevalent today that it interferes with the development of new and useful products (57 percent).

(*See, Appendix E, for a humorous commentary on our society's litigious climate.*[4])

The PPRC Report, the Harvard Medical Practice Study, and reports by the General Accounting Office (GAO) and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus:

> The current tort system, without modification, is unable to resolve liability claims cost-effectively and makes a haphazard contribution to deterring negligent behavior or improving the safety of health care.

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[3] Retained in Committee files: *Chart of Cost of a 1-year Malpractice Premium for an OB/GYN Practicing in DC vs. California, 1984 through 1990,* figures compiled by the American College of Obstetricians and Gynecologists.

[4] Retained in Committee files: Comic strip *HERMAN* by James Ungep.

Liability Reform Objectives Are Clear

There is a broad consensus about the objectives of health care liability reform:

1. Patient safety should be promoted

The HCLA believes that any meaningful reform of the liability system must contain meaningful patient safeguards against malpractice or harm from medical products or services. The health care community is committed to continuing efforts to reduce the incidence of injury and strongly supports reform efforts to promote patient safety and identify incompetent providers or unethical practices. Our efforts alone, however, are not enough to remedy the many harms that the current tort system perpetuates.

2. The system's focus should be compensation for injured patients, not lawyers

People injured in the course of receiving health care treatment are entitled to fair and prompt compensation. No one disputes this. Unfortunately, the current tort system has failed the patient population.

A February 1990 study by Harvard School of Public Health of hospital admissions in 1984 shows that of the one percent of patients whose medical records indicated some negligent treatment, only 12.5 percent filed liability claims. Significantly, only half of those patients—6.25 percent—received compensation from the tort liability system. (*Harvard Medical Practice Study,* Harvard School of Public Health, 1990.)

Other data show that even when patients pursue compensation, other parties to the system reap disproportionate benefits. Attorneys' fees and expenses (both plaintiff and defendant) account for 38 percent of total monies spent on resolving medical liability claims, according to the RAND Corporation. Ironically, while our system ostensibly is designed to compensate the injured, RAND estimates that only 43 cents of every dollar spent in medical liability or product liability litigation reaches injured patients.

Analysis of medical liability cases closed in California in 1993 indicate that the state's graduated limits on attorney contingency fees resulted in patients keeping an additional $9 million in compensation that would have otherwise gone to their attorneys. (*1993 Medical Malpractice Large Loss Trend Study,* Medical Underwriters of California, April 1994; see also, Appendix F, a 1989 Forbes article on the impact of excessive contingency fees on tort costs.[5])

3. The patient/provider relationship should be strengthened, not impeded

According to the Harvard Study, health care is completely safe for 99 percent of patients in hospitals. The health care liability system should be designed to target providers who engage in the one percent of cases that may involve unsafe or unethical practices. Instead, it currently creates an overall climate of fear and suspicion that impede the maintenance of trusting therapeutic relationships.

The average physician has a 37 percent chance of being sued at sometime in his or her career. This increases to 52 percent for a surgeon and 78 percent for an obstetrician. A compelling indicator of the current system's failure is the fact that *a physician's chance of being sued for medical liability bears little relation to whether he or she has been negligent.* The Harvard data show that 80 percent of the claims for medical negligence filed in New York did *not* correspond with a negligent adverse event. These findings reinforce the GAO's estimate that nearly 60 percent of all claims filed against physicians are dismissed without a verdict, settlement, or any payment of compensation in the plaintiff's favor (*Medical Malpractice, Characteristics of Claims Closed in 1984,* U.S. General Accounting Office, 1987). These numbers show that the current tort system as it functions in most states is not effectively resolving medical liability claims or deterring medical negligence.

4. The liability component of health care costs should be contained

We all bear the burden of the high health care liability costs paid by potential defendants, when these costs are passed on in the form of more expensive health care services. In assessing the full extent of liability costs, several component factors should be considered.

The first component is liability insurance premiums, which have been a significant factor in the increase in patient health care bills. In the 1980s, professional liability premiums were by far the fastest growing component of physicians' practice costs, increasing at an annual average rate of 15.1 percent between 1982 and 1989. (*The Cost of Medical Liability in the 1980s,* American Medical Association, 1992.) Estimates show that for each baby delivered in Florida, $1,119 goes toward payment

[5] Retained in Committee files: Article *The Best Paid Lawyers in America, Forbes, October 16, 1989.*

of liability insurance, and average premiums paid by self-employed physicians tripled in the 1980s. The cost is especially heavy for some high-risk specialists in certain states whose premiums have exceeded $100,000 and approach as much as $200,000 annually. The estimated annual cost of liability insurance for physicians and health care facilities has been placed at more than $9 billion in 1992 and continues to grow.

A second factor is the cost attributable to "defensive medicine," the term used to describe diagnostic tests and services motivated primarily by the fear of litigation and the perceived need to build a medical record that documents a health care professional's judgment. While difficult to precisely quantify, defensive attitudes and practices are real and entirely understandable when physicians have a 38 percent average chance (up to 78 percent for obstetricians) of incurring a claim regardless of the quality of care they provide. The AMA estimates that this practice added an additional $15.1 billion to the cost of health care in 1989. Lewin-VHI estimates the combined cost of physicians' and hospitals' defensive practices to be as high as $25 billion in 1991. (*Estimating the Costs of Defensive Medicine,* Lewin-VHI, 1993.) In an April 1994 study, the Hudson Institute's Competitiveness Center reported that liability premiums and defensive medical contributed $450 per patient admitted to a large urban hospital in Indiana, representing an average of 5.3 percent of the patient's health care costs. (DM McIntosh, DC Murray, *Medical Malpractice Lability, An Agenda for Reform,* Hudson Institute, 1994.)

According to the Lewin-VHI report, comprehensive medical liability reform as a component of health care delivery system reform could save an estimated $35.8 billion over the next five years by curbing premium cost and many defensive medical practices. The Lewin-VHI study predicts that tort reform savings will accrue at an accelerated rate as practice patterns begin to change.

The liability costs borne by makers of medicines and medical products contribute additional billions to the national health care bill. In 1990, $10.8 billion was paid to claimants in all health care product liability cases in the U.S.—and that does not include associated administrative and legal defense costs.

Adding these components together, the total cost of physicians' and hospitals' liability premiums, defensive medicine, and coverage for makers of medicines and medical devices, is more than $45 billion annually.

A final cost factor that is potentially enormous, but has not yet been adequately measured, is the liability of managed care systems for their utilization review activities that restrict payment for health care services that patients demand. Recent verdicts and settlement reports suggest that payors who refuse to provide services have multi-million dollar exposure, even if the medical service demanded by the patient has not been proven effective and is clearly excluded by the terms of the managed care plan. (*See Patients' Lawyers Lead Insurers to Pay for Unproven Treatments, New York Times,* March 28, 1994, page A1, attached as Appendix G.[6]) It is difficult to imagine any scenario in which cost containment initiatives can be successful, if the business risk in denying such benefits is a virtually unlimited jury verdict.

5. Medical innovation should be encouraged not derailed

The threat of liability acts to inhibit medical innovation and deprives health care professionals of certain medicines and medical devices needed for optimal patient treatment. The threat of litigation prompted seven of eight pertussis vaccine manufacturers to withdraw from the market between 1960 and 1985, even though no sound scientific study has even confirmed a cause and effect relationship-between the vaccine and any adverse neurological reaction. To prevent a dangerous shortage of the vaccine, the federal government established a compensation fund financed by an increase in the cost of the vaccine. Excessive litigation costs were also the reason that the manufacturer of the morning sickness drug Bendectin withdrew its product from the market, even though there is no credible scientific evidence to this day linking it to birth defects. Patients suffer needlessly because no substitute therapy for morning sickness has been developed—the product liability litigation risk is just too high.

6. Access to the comprehensive health care should be promoted

Perhaps the most serious societal harm caused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and/or to stop providing certain services in various areas of the country.

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[6] Retained in Committee files: *Litigious Patients Lead Insurers To Pay for Unproven Treatment, The New York Times,* March 28, 1994 by Gina Kolata.

Physicians and health care institutions have limited their medical practices in response to the liability climate. These restrictions on access to health care services have been seriously felt by obstetric patients, indigent patients, and those living in rural areas. Almost one out of eight obstetrician/gynecologists (12 percent) has dropped obstetrical practice as a result of liability risks. (*Professional Liability and its Effects: Report of a 1990 Survey of ACOG's Membership,* American College of Obstetricians and Gynecologists, 1991.) More than a half million residents of rural counties are without any physicians who provide obstetric services. (*Health Care in Rural America,* Office of Technology Assessment, September 1990.) Nor is this phenomenon limited to rural areas. An example of this problem was presented by Senator Riegle (D–MI) while chairing a 1991 hearing on health system reform, when he indicated that his family was unable to remain with its obstetrician of choice because that physician gave up obstetrics practice. This did not happen to a citizen in a rural community. It happened to a U.S. Senator in the District of Columbia (*See also,* Appendix H, a 1988 report on the impact of tort liability on physician participation in the Medicaid program prepared by the District of Columbia Medical Society;[7] and Appendix I, a 1900 Southern Legislative Conference report detailing numerous liability related access problems in rural areas.[8])

I can personally verify that the high costs of liability are a significant factor in the decisions of many physicians, in the District of Columbia and across the country, to drop or retire from high risk specialty areas such as obstetrics. Unfortunately, it is often the poor or uninsured in both rural and urban areas that are most affected. After many years of advocating reform in Washington—a city that desperately needs it—I am convinced that the serious access problem will not be remedied without strong national leadership.

Liability concerns are increasingly creating obstacles to the availability and affordability of medical devices as well. In response to hundreds of claims filed against them, E.I. DuPont Company is restricting the sale of its Teflon product to the makers of lithium batteries used to power heart pacemakers. Even though it had no role in designing the pacemaker device of the lithium batteries, because DuPont supplies a raw material it is included in the legal chain of responsibility. By virtue of their size a supplier like DuPont may have deeper pockets, and therefore may be more vulnerable to suit, than smaller companies who actually design or produce the product. For the same reason, DuPont and other companies are also restricting the sale of raw materials to manufacturers of jaw implants, artificial blood vessels, heart valves and sutures, among other devices. (*Implant Industry is Facing Cutback by Top Suppliers, New York Times,* April 24, 1994, page A1, attached as Appendix J.[9])

Until some reasonable limits are put on the liability exposure of defendants in health care injury cases—limits that provide fair, but not unlimited compensation for injured patients—these access problems will not be abated.

FEDERAL LEADERSHIP IS NEEDED

Every shareholder in the medical liability system has the opportunity and the responsibility to make the system work better. The health care community is actively carrying out its responsibility to identify and address high-risk of injury situations through a variety of patient safety and loss prevention programs in virtually every medical setting. Unfortunately, we can do little to remedy the waste in our country's tort system. We hope that other participants in the system will heed the call to participate in this effort. As the federal government fashions a nationwide overhaul of the health care delivery system, it should act to realize a viable and consistent solution to the panoply of issues raised by health care liability.

The litany of problems with the current tort system does not necessarily mean that the system must be abandoned. The HCLA believes that a fault-based system permits meritorious claims, screens out claims with no merit and lowers transaction costs can work. Reforms such as those adopted in the state of California tell us that the current system is a good candidate for reform, and that moderate reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation, and reducing the time required for claims resolution.

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[7] Retained in Committee files: A 1988 report on the impact of tort liability on physician participation in the Medicaid program prepared by the District of Columbia Medical Society.

[8] Retained in Committee files: *Medical Malpractice Insurance and Access Obstetrical Care, Southern Legislative Conference Report,* June 1990.

[9] Retained in Committee files: *Implant Industry is Facing Cutback By Top Suppliers, New York Times,* April 24, 1994.

Federal Preemptive Tort Reform

Federal preemptive tort reform represents a bold approach, but the only one that can advance a nationwide solution to this complex problem.

Virtually every health system reform bill introduced to date, including the Clinton Administration's Health Security Act (S. 1757/H.R. 3600) incorporates a federal preemptive liability reform title. (See Appendix K for a comparison of liability titles of major health system reform bills.[10]) Although the President and the First Lady should be commended for including liability reform concepts in S. 1757, the liability reform sections of their bill fall short of actions needed to accomplish meaningful liability reform.

In any federal preemptive scheme, states should be left with substantial power to implement additional or alternative reform programs that are equally effective at meeting federal objectives, and to experiment with a wide variety of alternative dispute resolution approaches to injury compensation. State-based demonstration projects like those now underway in Maine and a handful of other states to evaluate the use of clinical practice parameters/guidelines in litigation should also be helpful in evaluating whether such guidelines can reduce liability costs.

Necessary Reform Provisions Supported by the HCLA

The members of the HCLA agree that effective health care liability reform will not be achieved unless the reform provisions described below are adopted at the national level. These provisions are based on California's MICRA legislation, in place in that state since 1975. The California model ensures full and fair compensation for all actual losses, yet limits costs through various controls exerted on the "lottery" aspects of the medical liability system, notably a ceiling on non-economic damages and graduated limits on attorney contingency fees as claimants' awards rise. After nearly 20 years of experience in California, we can confidently conclude that California's limits on costs in high stakes cases have stabilized medical liability expenses overall, despite a pattern of long term growth in the frequency of liability claims in the state.

Apply liability reform provisions to all potential defendants in disputes arising from injuries received in the course of health care services delivery. Many liability reform titles, including the Health Security Act, apply only to malpractice actions brought against health care professional and institutional providers. Yet the manufacturers of prescription drugs and medical devices, providers of blood and tissue services or products, and managed care organizations are all at risk of lawsuit as well when a patient is injured. It should also be noted that hospitals, clinics and other institutional providers are sued not just for malpractice, but for personal injury alleged to result from their distribution of medical devices, pharmaceutical and blood/tissue material. Addressing the liability problems in just one part of the health care sector may actually stimulate litigation in other parts which are then perceived to have "deeper pockets." This detrimentally impacts medical technology manufacturers by deterring the development of new innovative, cost effective products. For all of these reasons, the liability reform umbrella should encompass all potential defendants in claims arising from injuries experienced in the course of health care treatment.

2. *$250.000 Non-Economic Damages Ceiling.* Limits on non-economic damages are the single most effective reform in containing medical liability premiums, according to a September 1993 report *Impact of Legal Reforms on Medical Malpractice Costs* by the OTA. Ceilings on non-economic damages do not in any way restrain the ability of a claimant to recover medical expenses, lost wages, rehabilitation costs or any other economic loss suffered as the result of a health care injury. It limits only those damages awarded for pain and suffering, loss of enjoyment and other intangible items. Based on the successful experience of California's MICRA legislation, HCLA members support a $250,000 limit. By international standards, this is a generous ceiling. No other country provides a benefit this high for non-economic damages.

3. *Several Liability for Non-Economic Damages.* Under the current rule in many states, a defendant that is responsible for as little as one percent of the total fault may be held financially accountable for the entire award. HCLA members agree that defendants should remain jointly liable to the plaintiff for all economic losses, but should be only individually liable for the portion of non-economic damages in fact attributable to their own acts or omissions. This compromise ensures that the

[10] Retained in Committee files: Comparison of medical liability provisions in health care reforms plans.

plaintiff will be made whole for all out of pocket losses, yet takes a step toward establishing fairness and accountability between defendants.

4. *Attorney Contingent Fee Limitations.* The contingency fee is meant to be the "poor man's key to the court house." However, the contingency fee system is not serving this function well. Most persons with small health care injury claims never get access to the civil justice system, because the contingency fee stimulates lawyers to be primarily interested in the "big ticket" cases. The system would be improved if the attorney contingency fee were calculated with some "relative value," similar to what the Medicare system now imposes with respect to physician fees.

All of the major health system reform proposals limit the amount an attorney can recover as part of a malpractice award. However, HCLA members cannot support the Health Security Act's contingency fee section which limits the attorney fees to a flat one third of the award, merely preserving the *status quo.* HCLA supports California's contingent fee limit schedule: 40 percent of the first $50,000, 33 and ⅓ percent of the next $50,000, 25 percent of the next 500,000, and 15 percent of any amount by which the recovery exceeds $600,000.

5. *Collateral Source Payments.* This reform would permit any defendant to introduce evidence of any reimbursement received or due to be received by a claimant from health or disability insurers or others for losses resulting from an injury. Claimants are permitted to provide evidence of amounts paid to secure the collateral source benefit. Providers of collateral source benefits would not be allowed to subrogate. The Health Security Act's collateral source provision would actually *offset* the award by the amount of collateral source payments received by the claimant. HCLA members believe that the Health Security Act's is not as effective as our proposal to inform the jury of such collateral source payments prior to their deliberations.

6. *Future Damage Awards.* Future damage awards over $50,000 should be paid periodically. The Health Security Act incorporates a periodic payment reform provision, but fails to establish a monetary threshold at which it would begin to apply.

7. *Statute of Limitations.* A uniform statute of limitations should be enacted that:

(i) Establishes a standard rule that claims must be filed within one year from the date an injury is *discovered,* but

(ii) Provides an outside limit of three years from the date the injury occurred. Exceptions to these general rules allowing extra time should be made

(iii) For children under age six who may not be able to communicate the existence of an injury, and

(iv) In the instance where a foreign body with no therapeutic purpose is left in a claimant's body and not discovered for many years.

HCLA COMMENTS ON THE HEALTH SECURITY ACT

The Health Security Act contains a number of additional reform concepts that may or may not be effective. We offer the following comments:

1. *Alternative Dispute Resolution (ADR).* The ADR section of the Health Security Act is expressly non-binding, presumably in deference to the cherished right of access to a jury trial. Yet, the central objective of ADR is to divert cases from litigation. This tension can only be addressed by giving parties to a health care injury dispute some incentive to voluntarily settle with the ADR decision and not pursue litigation. Two approaches should be implemented. First, the ADR decision must be admissible as evidence in court. The jury should be informed that the dispute already has been through some investigation or process and gives them the benefit of that process for their deliberation. Second, adopt a fee-shifting rule, whereby a claimant or defendant who rejects the ADR decision and goes forward is made responsible for the professional fees of the opposing parties if a result better than the ADR decision is not achieved. Finally, existing ADR provisions enacted by the states should not be preempted by federal law.

Many HCLA members believe that federal leadership in this area is best exercised by encouraging state or federal demonstration projects utilizing various ADR models. Because so little is clear presently as to the effectiveness of ADR, it may be appropriate to encourage state "laboratories" to try and evaluate different ADR approaches.

2. *Practice Guidelines.* The Health Security Act would establish a pilot program to encourage the use of clinical practice guidelines for the purpose of expediting the resolution of claims arising from care delivered in accordance with such guidelines. The HCLA would not oppose such demonstration projects, *so long as they*

require that practice guidelines be used exclusively as an affirmative defense by defendants in liability cases. This approach is consistent with demonstration projects already underway in Maine and other states.

3. *Certificate of Merit.* Non-meritorious suits will be discouraged if plaintiffs are required to have a qualified expert submit an affidavit stating that there is a likely breach in the standard of care. In the Health Security Act, the plaintiff's claim must be supported by a qualified expert. The Act should be strengthened by requiring a separate affidavit for each defendant and a penalty for experts who file affidavits in bad faith.
4. *Enterprise Liability Demonstration Project.* The Health Security Act's "enterprise liability" proposal would immunize physicians, nurses and other individual health care providers from responsibility for their actions and shift liability exposure to the health services "plan." This would only shift the associated liability costs, and instead of reducing them, could lead to higher losses because of the "deep pocket" theory. The HCLA adamantly opposes the authorization or expenditure of federal funds to encourage *mandatory* enterprise liability.

HCLA COMMENTS ON THE CHAFEE/THOMAS BILL (S. 1770/H.R. 3704)

The Health Equity and Access Reform Today Act (S. 1770) introduced by Sen. John Chafee (R–RI), contains one of the most comprehensive health care liability reform titles of any of the federal health system reform proposals offered to date, incorporating most elements of the HCLA list of necessary provisions with some variations. The members of the HCLA commend Senator Chafee and the other members of this Committee who have cosponsored S. 1770, including Senators Dole, Hatch, Danforth, Grassley, Durenberger, and Boren for their leadership on this important element of health system reform.

PATIENT SAFETY/RISK MANAGEMENT

Providing medical care today involves a complex system of persons and technology, each individual and component of which is necessary to bring about the safe and effective delivery of care to the patient. All of our activities aim at the common goal of improving patient health and preventing patient injury. All call upon us to examine what we do or fail to do, and how we do it. When problems are detected, solutions are developed and implemented.

Legislation designed to enhance patient safety must occupy a central role in medical liability reform. The members of the HCLA support a number of bills introduced in the 103rd Congress would implement this approach such as S. 1533/H.R. 3080, the "Affordable Health Care Now Act," introduced by Sen. Trent Lott (R–MS) and Rep. Robert H. Michel (R–IL). The HCLA supports the dedication of health care professional licensing fees to increase the effectiveness of state medical disciplinary boards. We also support the ability of states to enter into contracts with local professional societies to assist in investigating consumer complaints, which have the potential to significantly enhance the resources of licensing and disciplinary boards.

HCLA members remain committed to reducing the incidence of patient injury. In this context, we support required risk management training for health professionals and are proceeding with aggressive endeavors to restrict the ability of unethical physicians to practice medicine.

Conclusion

Mr. Chairman, our liability system needs to be fixed to meet the needs of injured patients who deserve to be fairly compensated, the health-care sector, which is willing to assume their fair share of the responsibility for avoidable patient injury, and society, which needs to reduce transaction costs, eliminate windfall judgments, and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties.

I appreciate the opportunity to appear before the Committee and would be pleased to respond to questions.

APPENDIX A

HEALTH CARE LIABILITY ALLIANCE MEMBER LIST (COMPANIES & ASSOCIATIONS)

American Academy of Dermatology
American Academy of Ophthalmology
American Home Products Corporation

American Hospital Association
American Medical Association
AMA/Specialty Society Medical Liability Project
American Society of Healthcare Risk Managers
Biotechnology Industry Organization
Californians Allied for Patient Protection
Council of Community Blood Centers
The Doctors' Company
Health Insurance Association of America
Health Industry Manufacturers Association
Medical Protective Company
Medical Mutual Liability Insurance Society of Maryland
MEDMARC Insurance Company
MMI Companies, Inc.
National Association of Manufacturers
National Council of Community Hospitals
Pharmaceutical Research & Manufacturers of America
Physician Insurers Association of America
Physician Insurance Company of Michigan

Senator HEFLIN: Mr. Schwartz?

STATEMENT OF VICTOR E. SCHWARTZ

Mr. SCHWARTZ. Good morning, Mr. Chairman. Thank you for inviting me here today. I want to make clear that I am just presenting views that are my own views. I am not representing any group, and I know that you appreciated that, and that made me especially appreciative of your invitation, that I have been asked here because of my expertise.

I do write in the field; for the past 20 years have done a casebook on tort law; I have represented plaintiffs in this area as well as defendants. My good colleague, Mr. Corboy, who moved to my left, strangely, as we were about to sit down, will make some very persuasive arguments to you and have lots of charts, but I will just make a few points and hope that you will recall them after his presentation.

I think if you are going to deal with health care in a comprehensive way, there is no doubt that our liability system is part of that, and so it is logical and common sensewise to include addressing medical liability.

There have been in the law unfair restrictions on plaintiffs as well as defendants, and I would make that point first. When I began teaching, there was something called the locality rule, which in effect prevented any plaintiff's lawyer from getting an expert to be able to prove medical negligence, because people in the immediate locality would not testify against other doctors. That has been eliminated from the law.

Senator HEFLIN. Not all the States.

Mr. SCHWARTZ. Well, I think if there are any States that still have it, that is a good issue to address. What I am suggesting to you, Mr. Chairman, is that if the Congress addresses this issue, both situations that are of concern to plaintiffs and to defendants should be addressed. Statutes of limitation in some States I think are unfair because people may lose their right to sue before they know or have reason to know that they have been hurt or the cause of that hurt. That can occur both when patients are alive or in wrongful death cases. In most of our States, wrongful death begins

at the time of death, regardless of whether the family knows or has reason to know the cause of it.

So I think those things should be addressed, too.

Ms. Lebow discussed the collateral source rule. We have a lot of information from the States about that, and I suggest that the Subcommittee look at it very carefully. Some States allow the introduction of a collateral source before the jury. You will find, if you take that approach, that it is much simpler and easier to do than trying to eliminate the collateral source rule altogether. But it also has an arbitrariness because jury "A" may consider the collateral source, and the second jury may not.

If you do eliminate it, I think it is fair to eliminate it when the initial premium has come principally from a source other than the plaintiff himself, which gets to an earlier question of yours, Mr. Chairman. When the Government, an employer or other source has paid a substantial amount of the premium, a fundamental reason for the collateral source rule has disappeared, and that gives you reason and logic to eliminate it. If you do eliminate it, you should address the issue of whether the insurers or others who were the collateral source should have the right to subrogation and join in the suit. If you give them subrogation rights, in effect you are going to eliminate most of the savings for the defendant that you started to have when you put the collateral source rule reform in the first place.

If you do not, and you do not allow subrogation, then it allows someone who is engaged in wrongdoing to externalize the cost of their wrongdoing and have somebody else pay for it. It is very important to address it.

Caps on pain and suffering are the hot button. People are going to debate it, and they are going to have very different, diametrically opposed views. I would just suggest that you look at the States where those caps have been imposed. What has happened there? Has the incidence of medical malpractice increased? Have they had a bad effect on society? What has been the effect? And if it is negative, you look askance at them. And if they have not produced the problems that people have claimed, then maybe they are more positive.

The principal criticism of them is that they are arbitrary. But pain and suffering damages, on the other hand, are arbitrary, too. Two juries with the exact same injury can vary between $100,000 and $1 million for the same pain and suffering damages. There is New York data that you will find on this, and you will see that arbitrariness is in the eye of the beholder with that particular issue.

Periodic payments. My own view is that they are good if well worked out. You have to properly provide for the attorney's fees so he or she is treated properly. You have to see that they have reached present value. I will tell you what I like about them. I like them from my experience of representing plaintiffs. When somebody who normally does not have a large amount of money suddenly has $1 million or $2 million or $3 million, frankly, they have difficulty knowing what to do with it. Sometimes, they make very bad investments with it; I have seen that. On the other hand, my most recent case, which was just 3 years ago, involved a situation where a person was afraid to touch the capital and did not.

I want to make sure that one point is made that is maybe the most important point, and that is the kaleidoscope effect of tort law. All of us have seen a kaleidoscope. You look in it, you tilt it just a little bit, and you have a totally different picture.

If you impose ADR's, limits on damages, with one group of defendants, what will happen in our system is that limit will shift over to other defendants in the Health Care System. What happens is, since there is joint liability in most States, the plaintiff's attorney—wisely—will try to pick up the lost piece from some other defendant in health care liability. That is why if you address this topic, it is health care liability. It is not medical malpractice. It is entwined and is a whole, and any limits or changes that are significant in damages should apply to all parties.

Attorney's fees have been mentioned, and this may surprise my colleague, but I have never liked putting fixed limits on attorney's fees. I think that they are arbitrary. If you take even the President's plan of 33 percent—and some people who know plaintiffs' attorneys usually charge that have said maybe the defendant should charge $3.50 an hour and make it even—but I think they can be arbitrary. Some cases are slam dunk. There are cases where a doctor has left an object in a patient's abdomen. There is doctrine called res ipsa loquitur. It is a pretty easy case to try, and something like that may not be worth 33⅓ percent. On the other hand, there are cases that are very complicated that Mr. Corboy has handled where 33 percent or 20 percent or 25 percent may not be the proper fee.

I think the key thing here is to see that there is adequate disclosure by attorneys on both sides of the aisle, both plaintiffs and defendants, to their clients so that the client can make a reasonable evaluation of the worth of the service.

There are many other topics that I have not discussed today, but I see the red light on, and I will not talk over it. I thank you for considering my views.

Senator HEFLIN. Thank you.

[The prepared statement of Victor E. Schwartz follows:]

PREPARED STATEMENT OF VICTOR E. SCHWARTZ

Mr. Chairman, I wanted to express my deepest thanks to you for your kind invitation to testify before your Committee about medical malpractice reform. For reasons that I will expand upon, I see the topic a bit broader, and that is health care liability reform—liability in this particular area is blended and infused; it incorporates all parties in the health care system. Your kind letter predicated my invitation on my expertise and interest in this issue.

That interest goes back over 30 years when I first studied tort law. For the past 20 years, I have co-authored Prosser, Wade and Schwartz, *Cases and Materials on Torts,* the ninth edition of which has just been published. Approximately, 15 years ago, the topic of professional liability became so important that we presented it as a separate topic in our casebook. I have also had the benefit of private practice and represented both plaintiffs and defendants in the area of medical malpractice. My testimony today is based solely on those experiences. I am not representing any interest group or client—I think, for better or for worse, that will become clear in my testimony.

Other panelists have discussed and debated whether there is need for reform in this area. From my perspective, if the topic of health care is to be considered in a comprehensive way at the federal level, it is just and logical to include provisions that address health care liability. It is not an easy task, as many of the doctrines are subtle and can have unintended and adverse implications if addressed in an inappropriate way. Also, there is an absolute need to create a balance so that:

(1) Persons who have been injured by negligent treatment are adequately compensated,

(2) The tort system maintains necessary deterrence against wrongful conduct, and

(3) The tort system is not wasteful in creating unnecessary transaction costs or extravagance in awards.

UNFAIR RESTRICTIONS ON RIGHTS OF PLAINTIFFS

When I began teaching tort law in 1967, I thought the medical malpractice laws in many states were unfair to victims. At that time, the so-called "locality rule" was a principle of law in many jurisdictions. The "locality rule" meant that a plaintiff could not prove his or her case unless an expert testified from the locality in which the alleged malpractice occurred. Under this rule, plaintiffs struggled, often without success, to obtain an expert to prove a case. Fortunately, the "locality rule" is now a dead letter, and the law allows plaintiffs to introduce experts from outside the locality who would have available to them similar information and resources as a defendant doctor. There has been a problem, however, in the pendulum shifting too far the other way in some jurisdictions—experts are permitted to testify who may not have conducted appropriate research or who may be simply persons who testify for a living. This can occur on either side, plaintiff or defendant, and it is an area of worthwhile focus and reform.

In 1967 and in some jurisdictions today, plaintiffs are sometimes trapped by statutes of limitations that are unfair. The law should allow a person's claim to be preserved until a reasonable time after he or she has discovered both that there has been an injury and the cause of that injury. In the context of health care liability, it is also important that claims be brought to court in a reasonable time before evidence becomes stale or unavailable; there is a problem with extensions of statutes of limitations in some jurisdictions because of unnecessary tolling.

Today, I would like to focus on the main topics that appear in a number of the principal bills on health care.

COLLATERAL SOURCE RULE

The President's Plan—include reform of the collateral source rule

The collateral source rule says that a defendant is not able to show or tell the jury that the plaintiff has already been compensated for all or part of an injury by another, or "collateral" source. Probably, the rule would be better understood if it had a more common name. The basis for the rule is that a wrongdoer is not supposed to profit from a plaintiff's prudence in obtaining insurance or in otherwise financially protecting himself or herself from a loss. The reason for the rule is undercut, however, when the plaintiff has not fully paid for the collateral source—*i.e.*, when that payment is made by an employer, by government or other sources. This is why it is rational, in the context of health care reform, to consider modifying or eliminating the rule when the source of payment of the collateral source is by parties other than the plaintiff.

Many states have made inroads on the collateral source rule, and they do provide a laboratory for considering the best approach. One approach is simply to inform the jury of the collateral source, that the plaintiff has been paid by somebody else and a payment from the defendant would constitute double payment. This approach is preferred by the Health Care Liability Alliance (HCLA), and a point in favor of the approach is its simplicity. On the other hand, different juries might decide different ways with respect to the exact same evidence—under this approach, the jury can or cannot ignore the collateral source.

The President's bill and several others eliminate the collateral source rule when the source has been paid for, in whole or in part, by someone other than the plaintiff. This is a more predictable approach, but does require careful attention to the following issues:

1. Who calculates the amount of collateral sources? I suggest that it be made by the court prior to the case going to the jury. The court can consider not only past but future payments of collateral sources, whether they might expire and other special conditions. The jury would then be informed of uncompensated economic losses endured by the plaintiff.
2. Whether subrogation rights are to be preserved or eliminated? If the payment has been made by a health care provider or other source, will it be allowed to join in the action and obtain what it has already paid to the plaintiff? If subrogation is allowed, a great deal of the savings to defendants brought by the collateral source reform will be eliminated. On the other hand, if subrogation is not allowed,

liability costs will shift from defendants or their insurers on to health care or other non-liability insurers.

CAPS ON PAIN AND SUFFERING DAMAGES

A number of states, including California, have placed some limit or "caps" on the amount of so-called "non-economic" or "pain and suffering" damages a plaintiff can receive in a malpractice action against a doctor. Under the California approach, the limit is $250,000. The basis for this reform, in part, is directed at saving excessive costs—if damages are capped, liability costs should be reduced, and there are studies that show that this is true. It can facilitate quicker settlements, reduce the cost of medical malpractice insurance, and put a damper on the erratic nature of jury verdicts. If this reform is pursued, it is important to consider whether incidents of medical malpractice rose or did not rise in states that have had caps. My understanding is that they have not risen, but this is a matter that the Subcommittee should carefully consider. The principal argument against caps is that they are arbitrary in nature and that a jury should decide how much non-economic damages the plaintiff has endured. Of course, the jury's award, itself, can have an arbitrary ring. There are no "pain and suffering" stores and no ready market value or objective means for determining this type of damage.

In any case, if this reform is undertaken, it is a good idea to have the court impose the cap; otherwise, the cap ceiling well could be the floor for pain and suffering awards, *e.g.,* juries may tend to award the full amount of the cap. This approach will also provide helpful information about whether the cap is realistic in light of views expressed by many juries.

PERIODIC PAYMENTS

The President's plan and several other bills suggest that when a jury award is above a certain amount, *e.g.,* $100,000, damages should be paid in periodic payments. Well-crafted, this is a good idea. My experience with victorious plaintiffs is that they often have difficulty in suddenly having the responsibility of managing a very large amount of money. It is sound public policy to help assure that money that is directed toward compensating plaintiffs for future losses be used for that purpose: used to pay for medical care, to be used to replace loss of wages. Some plaintiffs, who are not used to handling large amounts of funds, may lose their jury award in bad investments or in other ways. Other plaintiffs, and I think of one case in particular that I was involved in a few years ago, are afraid to touch such large amounts of money, and they endure needless suffering because of their apprehension about "delving into capital." Periodic payments, well-constructed, can help avoid these problems. For defendants, it allows them to pay large verdicts over time. If the reform is undertaken, the bill should indicate how present values are to be handled and, also, how the attorney's fee is to be calculated. In my judgment, it should be calculated out of the present value of the award.

ALTERNATIVE DISPUTE RESOLUTION MECHANISM

Almost all of the health care bills have some form of alternative dispute resolution mechanism (ADR). ADRs have become popular, but if they are to be a true cost-saving device, it is important to look at state experience and see which approaches have worked best. My understanding is that the Early Neutral Evaluation system used in northern California has been effective. I will submit information to the Committee about this approach, but the general point is to not embrace fads, but facts.

ATTORNEY FEES

Limitations on attorneys' fees do not "save money" for defendants, but they can allow injured persons to receive larger awards. Obviously, if they pay their attorneys less, they will get more. One has to be careful in this area so that one does not impose regulations that are so severe that injured parties cannot obtain attorneys to represent them. Also, one must appreciate that the value of attorney services varies greatly, depending upon the circumstances of the individual case. In a "slam dunk" medical malpractice case, *e.g.,* a doctor has left surgical tools in a patient's abdomen (this has happened), the fee should not be very high. On the other hand, in a complicated medical case involving experts and complex determination of causation and fault, it may be that an appropriate fee is more than the standard 33⅓ percent. In my judgment, appropriate flexibility should be involved in any fee structure scheme, and full and complete information about the fee and the amount of time that has been expended in pursuing a claim should be provided to clients

on both sides, plaintiff and defendant. This will allow both plaintiffs and defendants to evaluate the reasonableness of the legal services they have received and help promote a market solution to any problems that exist.

THE TORT KALEIDOSCOPE

Back in 1972, when I wrote my first book which was called, *Comparative Negligence,* I found that if you make even a simple change in one doctrine in tort law, it can have a broad impact throughout the tort system. The slight shift is like turning a kaleidoscope: the pieces might be the same, but you may have a whole different picture. When one is fashioning legislation of this type, especially involving any limits on damages, one must calculate how the rule of law will work in the rest of the legal system. Let us take a specific example. If a cap on pain and suffering damages or a collateral source limitation is imposed on one group of defendants, *e.g.,* health care providers, and it exists in a state that has full joint liability, whatever "savings" are brought about by the cap, may be shifted over to other defendants. If a jury's award is $1 million for pain and suffering damages, but one group of defendants is capped at $250,000, under joint liability rules, the other defendants who may be only partially at fault will have to bear the cost of the remaining $750,000. For that reason, any legislation that embraces these limits should include in its coverage all defendants who are brought into the liability action; otherwise, one is not engaging in cost saving, but cost shifting.

This may not manifest itself if one is focusing on a tort rule that is highly specific to medical malpractice , *e.g.,* a rule specifying a physician's duty to provide informed consent.

PUNITIVE DAMAGES

A number of health care bills address the issue of punitive damages. As this Subcommittee knows, there has been debate about whether punitive damages are or are not a problem; in point of fact, as one of the experts who did an intense study suggesting that punitive damages were *not* a problem said:

> The actual number of punitive damage awards in products liability litigation is unknown and, possibly, unknowable because no comprehensive system exists.

See Professor Michael Rustad, "Demystifying Punitive Damages in Product Liability Cases: A Survey of a Quarter Century of Trial Verdicts," Roscoe Pound Foundation, Washington, D.C. (1992).

I think one makes more progress in this area by avoiding "data wars" (how many claims exist) and by focusing on whether rules are fair.

Let me focus on one area that can be very unfair unless a federal solution is provided. In the context of medical liability reform, some defendants may be charged with a multiplicity of punitive damage claims for what is, in essence, one act or course of conduct, *e.g.,* a hospital is negligent in maintaining a doctor, or a health care provider is negligent in having him or her on a recommended list. It would be sound social policy to address this problem—it can only be addressed at the federal level. Multiple imposition of punitive damages can put a hospital out of business before some injured people receive compensatory awards. There should be reasonable limits on the multiple imposition of punitive damages for what is the same or similar conduct. If a jury has had the whole picture and made an adequate award, fairness would suggest one punishment is enough. If the whole picture is not there, it is appropriate to have the punishment measured against the conduct that had not previously been considered.

CONCLUSION

There are many other crucial issues that I have not addressed today, such as rules on informed consent, the development of practice standards and enterprise liability. I would be pleased to respond to the Subcommittee's questions about them. I commend you, Mr. Chairman and Members of your Subcommittee and the Judiciary Committee, for carefully examining health care liability—it is part of the health care problem. If action is taken, it should be meaningful and balance the interests I discussed at first: providing adequate compensation for those who are injured through the fault of those involved in the medical care system, providing adequate deterrence, and reducing transaction and unreasonable costs that have become part of the health care liability system. I would be pleased to assist the Subcommittee in whatever way you regard as feasible in accomplishing this goal.

SUMMARY OF TESTIMONY OF VICTOR E. SCHWARTZ

- If the topic of health care is to be considered in a comprehensive way at the federal level, it is just and logical to exclude provisions that address health care liability.
- Health care liability provisions should balance providing adequate compensation, deterrence and reducing transaction and unreasonable costs.
- Unfair restrictions on the rights of plaintiffs, as well as unfair burdens on defendants should be addressed.
- Health care liability reform should embrace all participants in the health care system; otherwise, one is engaging in cost shifting, not saving.
- Fair statutes of limitations should prevent people from losing a claim before they know how and when they have been hurt; however, statutes should not allow evidence to become stale or unavailable.
- Modification of rules that allow double payment to plaintiffs should be modified if the source of one of these payments was government, employers or persons other than the plaintiff.
- "Caps" or limitations on pain and suffering damages have reduced the cost of liability insurance. Such limits should not be favored if it is proven that they will increase malpractice.
- Periodic payments are sound reform because they help assure that liability awards are used for their intended purposes.
- If alternative dispute resolution mechanisms are to be adopted, empirical evidence should show that they are effective.
- Fair rules should address multiple imposition of punitive damages.
- Full and complete disclosure regarding attorneys fees are sound reforms. Any fee limits should have flexibility so as to allow for the value of the underlying work performed by the attorney.

Senator HEFLIN: Mr. Corboy?

STATEMENT OF PHILIP H. CORBOY

Mr. CORBOY. Mr. Chairman, Senators, thank you.

I represent an organization that has 680,000 lawyers in it. It is the American Bar Association. There may be more next year. There certainly will not be less, except those who pass away, supplying a natural attrition. But the statements I have heard this morning and the statements I heard last week when I was before another committee indicate to me the integrity, I think, and the efficacy of the American Bar Association's respectful and professional antagonism to federalization of malpractice laws.

The more we hear, the more we hear that people can take care of it by themselves, or that they cannot take care of it by themselves. Most of the States have already engaged in some type of tort reform. My State has engaged in quite a bit of tort reform. California and Massachusetts have engaged in extensive tort reform on a medical malpractice basis.

But what is it we are trying to supply? If I were a doctor—and I have a son who is a doctor, and he would agree with this statement—if I were a doctor, I would like to be immunized so that I could not be sued at all. If I were a housewife, I would like to be immunized so that I could not be sued at all. If I were a cab drive, a truck driver, an airplane pilot, a manufacturer of a product, I would like to be immunized. I think that is the natural ambition of people in a system.

I have never met a doctor who would suggest that his wife, if injured, should be subject to the reforms that they would like to engage in themselves. It just does not happen. It all depends on whose ox is being gored.

Now, I have to talk in negative terms because most of the tort reform is in negative terms. It inhibits and restricts the rights of people who have been seriously injured.

I can very easily appreciate the angst that a doctor or other health care provider goes through when he or she is sued. I do not like being sued, and I have been sued. Fortunately, I had malpractice insurance. That is what our system is all about. You cover yourself; you enter into a contract.

I do not like paying a premium, but a good 40 percent of that premium is deductible. It is a business expense. Most people who engage in malpractice lawsuits today are unaware of the statistic that those cases that go to trial, the doctors win 70 percent of the cases.

What type of reform is needed? Do we want them to win 85 percent of the cases? If I were a doctor, of course. The only way you are going to reduce malpractice claims is to reduce malpractice.

It may well be—and I hope Dr. Niles does not become too insulted by this; I do not mean to insult him at all—it may well be that the doctors in this community of the District of Columbia are more negligent than the doctors over in the adjoining State, and maybe that is why they get sued more often. I do not think federalization of the tort system in medical malpractice cases will change anything.

Let us go to the most seriously suggested change, and that is caps on economic damages. We have a chart for you, supplied by a Government entity, which shows the tort changes that have occurred in States throughout the entire country. It is Exhibit C in the paper we gave you.

Massachusetts and California have the most drastic tort reform of any States in the country. Yet Massachusetts and California are the two leading States in the cost of medical care. Tort reform has not reduced medical care expenses in the two States where the most drastic tort reform has occurred.

The suggestion that we have caps—and the corresponding suggestion that there is a lot of defensive medicine—if I were a doctor—and again, I say this with due respect to any medical care provider here—I would be ashamed to suggest that I render care or subscribe to or prescribe procedures which are not necessary. I am not suggesting that doing that is an actionable malpractice action, but it is certainly malpractice.

There is no locality in this country that would allow for defensive medicine to be regarded as a legitimate cost. You cannot have it both ways. If you are going to satisfy the standard of care in a community under the locality rule, or if you are a specialist under a general American rule, you cannot suggest that you are going to give a procedure that is not necessary. It just does not jive. You may be forced into it by fear of malpractice, but it does not make it any better.

I might also say that because they win 70 percent of the cases, what is the reason for requiring caps on the people who most need them? There was a case in Florida recently where the jury awarded $2.7 million to a lady who had the benefit—or the victimization—of a doctor not supplying proper oncology treatment to her breast. She lost a breast needlessly. The verdict was $2.7 million. If there

is a case that deserves $2.7 million, it is every doctor's wife in the country; it is every lawyer's wife in the country; it is every lobbyist's wife in the country; it is every Senator's wife in the country. Compensation amounting to $2.7 million is not a lot of money to a woman who has been psychically injured, as well as physically.

If that woman had been blinded, if that woman had lost an arm, she would have been entitled to $250,000. Now, that does not make sense. Why should the person who is the most aggrieved, the most damaged—the poor; the minorities, all of them; those people who are not earning a lot of money; women who are not out working; students who do not yet have a history of working for a living and having an income—would all be the ones who would be the beneficiaries of tort reform. They would be restricted to a $250,000 cap, arbitrarily created, because they did not have any other damages. And therefore, their maximum would be $250,000. The most seriously injured will be the ones most victimized.

With reference to defensive medicine—without completely suggesting—there are no figures on defensive medicine. I have a document in my papers here that suggests, however, that the American Medical Association does not recommend or find that it is 15 percent of medical care; they say it is a maximum of 2 percent, not 15 percent. Now, assuming it is whatever it is, if you go to a doctor, is that doctor going to say to himself, I am covered here because this person is a child, or this person is a housewife, or this person is a retired U.S. Senator; therefore, I am not going to engage in defensive medicine because I will only get hit for $250,000? That does not make sense, does it?

If the doctor is going to be subject to the advantage of the victim, subject to the disadvantage of a cap, there is only one person whom it makes any sense to protect, and that is an insurance company. That is an insurance company that sells insurance premiums to doctors.

Now, there is actually no doubt that if you cut the benefits, you can cut premiums. Certainly, you cut premiums in California and Massachusetts; you took away the rights of people to recover, but you did not decrease medical expenses in those two States, and the other States that have had it.

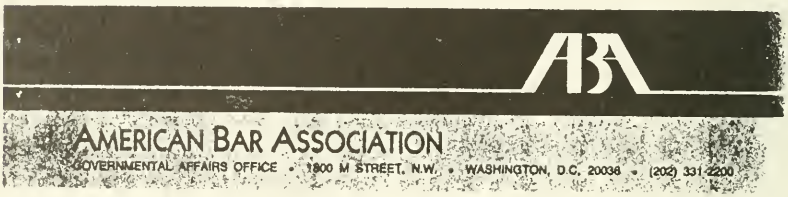
If I were to say I am going to start a new insurance company, and we will call it The U.S. Senator, Inc., and I am going to sell insurance to every U.S. Senator who happens to be a male, and if that male were killed on July 4, in Afghanistan, we will sell him insurance—can you imagine how low the premium would be?

Well, obviously, you can take the premiums that doctors pay, or that all medical care providers pay, and if you take out the legitimate bases for coverage—damage to the psyche, damage to the arm, damage to the leg, damage to the entire body—and put a limit on it, of course there is going to be a premium diminution. Of course, there will. But I do not think that that is what the U.S. Government should be interested in. The U.S. Government, in addition to nonfederalizing, should not only leave it up to the States, where they have handled it pretty well—people in California apparently like that, or they would repeal it. We have malpractice in Illinois which we may not like, but we have them.

I respectfully suggest there is not only no need for federalization of malpractice laws, but if there is one, it is not in any way regarded as having anything beneficial in caps, other than to insurance companies.

Thank you.

[Philip H. Corboy submitted the following material:]



Statement of

PHILIP H. CORBOY

CHAIR

of the

SPECIAL COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY

on behalf of the

AMERICAN BAR ASSOCIATION

before the

SUBCOMMITTEE ON COURTS AND ADMINISTRATIVE PRACTICE

COMMITTEE ON THE JUDICIARY

of the

UNITED STATES SENATE

on the subject of

MEDICAL PROFESSIONAL LIABILITY

May 24, 1994

SUMMARY

Since 1972, the ABA has been on record in support of legislation that would provide for every American access to quality health care, regardless of a person's income. In February 1992, the ABA's House of Delegates reaffirmed its support of such legislation, and called for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation and a concept the American Bar Association supports.

Access to the American legal system has also been a fundamental right tracing back to the beginnings of our country. We understand the concerns being expressed about the issue of medical professional liability. The ABA is deeply committed to having a legal system in America that is effective and just and one that protects the rights of plaintiffs and defendants.

An October 1992 Congressional Budget Office study reported that medical malpractice premiums account for less than 1 percent of the dollars spent annually on the Nation's health care. These premiums include the compensation made to individuals because of malpractice.

The report also concluded that much of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about medical malpractice. CBO noted that physicians have always sought to provide patients with the best possible medical care at the lowest risk and would continue to do so even without the threat of lawsuits. Because much of this defensive care helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice "reforms."

Some have asserted that medical malpractice reforms proposed by the American Medical Association, such as caps on noneconomic damages, would reduce health care costs for everyone. The ABA Special Committee on Medical Professional Liability researched the issue. As set forth in the chart found at Appendix "C" of this statement, it discovered that personal health care costs per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. Thus, it appears that "reforms" such as caps on damages have no real effect on the cost of health care in the United States. Such reforms do, however, have a significant impact on those people who are injured as a result of medical negligence.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously injured persons would be fully compensated.

Elimination of the collateral source rule passes on the costs of a medical injury from the medical professional liability insurer to another insurer or provider of benefits. Where the government provides health insurance benefits, government health care costs would increase.

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to present the views of the American Bar Association on medical professional liability in the context of proposals to increase access to health care. I am Philip H. Corboy, Chair of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1992, the ABA's House of Delegates reaffirmed its support of legislation calling for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked towards this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by ABA Past-President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution upon recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded. However, it was reactivated in August 1991.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a state Supreme Court justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers.

In February 1987, the ABA House of Delegates considered the Commission's recommendations and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level. The tort system has shown considerable resilience in the face of dramatic social and economic developments. State courts and legislatures are constantly working to improve the tort laws and should be permitted to continue to do so. Thus, federal intrusion into the field, with some discrete exceptions, is inappropriate.

The ABA believes that federal pre-emption of the state medical professional liability laws would constitute an unwise and unnecessary intrusion of major proportions on the long-standing authority of the states to promulgate tort law. Such pre-emption would cause the whole body of state tort law to become unsettled and create new complexities for the federal system. Unequal results would occur when medical professional liability litigation is combined with other fields of law with differing rules of law. An example of this would be a situation where a medical malpractice claim is joined with an automobile liability claim. If state tort laws differ from the federal law in areas such as caps on damages, the collateral source rule or joint and several liability, conflicts and uncertainty would likely result; and one defendant in an action could well be treated entirely differently than another. Having one set of rules to try medical professional liability cases and another set of rules to try other tort cases is not consistent with the sound and equitable administration of justice.

Our ABA policies reflect the ABA's recognition that the issue of medical professional liability is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by a provider of health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that

right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are especially concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants -- in this case, the medical profession It is the ABA's belief that the rights of injured persons to recover fully for injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs make up only a small fraction of the dollars spent on health care in the United States, the changes in the tort laws would have no real impact on costs of health care.

In addressing access to health care proposals, that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of the injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

<u>What is the Cost of the Medical-Legal System?</u>

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of that care are:

* Reliance on modern, sophisticated and expensive treatment.

- Innovative treatment of illnesses, such as heart disease, AIDS and cancer;
- An aging population, which adds to Medicare and Medicaid expenditures;
- High administrative costs of the health care system; and
- The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant. The Congressional Budget Office stated in 1992 that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the national health expenditures.[1] I understand that these insurance premiums account for a lower percentage of national health expenditures at this point in time. The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated. However, no one has reliably measured what, if anything, defensive medicine costs.

An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high-cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."[2]

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. However, there is no agreement upon the definition.[3] That uncertainty has resulted in the inability to statistically measure the cost.[4] In published studies, "defensive medicine" has included erroneously

the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.[5] Some have considered the cost of new technology and advancements in medical knowledge, care and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There has been no study to measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.[6] When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.[7] Thus, if liability concerns are a deterrent, provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care costs.

Because no reliable studies have been done to estimate the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study in 1994.

HAVE TORT PROPOSALS, WHEN ENACTED, LOWERED OVERALL HEALTH CARE COSTS?

It is often asserted that caps on noneconomic damages and elimination of the collateral source rule result in lower health care costs for everyone. In general, these types of proposals have been enacted only within the last ten years. Insufficient time has elapsed, and insufficient data has been gathered to enable us to be certain of the impact on costs of these proposals. However, from our research and study it appears that these proposals have not had any measurable impact on overall health costs. In looking into the issue we found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. We developed a chart (attached as Appendix C) showing the percentage of increase from 1982 to 1990 in

personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

As the chart demonstrates, personal health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

Our findings are consistent with other studies. For example, in March 1993, the Coalition for Consumer Rights published False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs. This study found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average."[5] Regarding caps on damages, the Coalition's study concluded as follows:

> Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30% of the ten states spending the least in health care have enacted limits on recovery of damages; 55% of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is no correlation between the least expensive states and limits on damages.
>
> Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.

A 1992 study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas."[9]

The cost of medical malpractice insurance, for the most part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have been relatively stable in recent years.[10] The number of medical malpractice claims peaked in 1985, and has continued to decline according to the most current figures available. From 1985 to 1990, the overall rate declined at an average annual rate of 8.9 per cent.[11]

WHAT ARE THE CONSEQUENCES TO THE PUBLIC OF PROPOSALS TO CAP NONECONOMIC DAMAGES OR ELIMINATE THE COLLATERAL SOURCE RULE IN MEDICAL MALPRACTICE CASES?

Proposals of this type are ill-advised. Elimination of the collateral source rule solely favors medical professionals by passing on the cost of the medical injury to another health care provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, government health care costs would increase. The net result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public -- injured persons -- of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are victims of medical malpractice.

SHOULD ALTERNATIVE DISPUTE RESOLUTION BE INCLUDED IN A NATIONAL HEALTH ACCESS PROPOSAL?

The ABA has long supported the use of various methods of alternative dispute resolution (ADR) and was an early leader in advocating for its use. We encourage providing appropriate ADR options in a national health access proposal as an efficient means of expediting medical malpractice claims.

In 1976, the ABA co-sponsored a conference in St. Paul, Minnesota. The conference sought to address two principal topics: "What types of disputes are best resolved by judicial action and what kinds are better assigned to another more appropriate forum?," and "Can the interest of justice be better served with processes less time-consuming and less expensive?" The conference discussions led to the appointment of a "Pound Conference Follow-up Task Force," under the chairmanship of Judge Griffin Bell. The Task Force published a report with numerous recommendations for justice reform in August, 1976.

A principal recommendation of the report is that a variety of innovative dispute resolution techniques be explored: arbitration, mediation, revitalized and expanded small claims courts, and the concept of a "neighborhood justice center."

In 1977, when the ABA established its Standing Committee on Dispute Resolution, that subject was relatively obscure; how

ever, during the past 16 years, the ABA through its Standing Committee and its newly established Section on Dispute Resolution, has chartered the nation's dispute resolution agenda. The Multi-Door Courthouse, school mediation and police dispute resolution programs were unknown concepts until after the ABA's 1976 Conference on Improvements in the Administration of Justice.

Today, the dispute resolution world is dramatically different. Much has happened, in part because of ABA leadership. The extensive work of the ABA is described in a document entitled the ABA Blueprint for Improving the Civil Justice System. Copies of the "Blueprint" are available upon request.

The ABA's House of Delegates has adopted four resolutions relevant to ADR and medical malpractice. The resolutions call for the following:

1. To promote continued use of and experimentation with ADR, both before and after suit is filed, as welcome components of the justice system. (Adopted August 1989.)

2. Consistent with the attached ABA policy (Appendix D), to support the increased use of ADR by federal agencies, which included support for the recently passed Administrative Dispute Resolution Act of 1990. (Adopted August 1988.)

3. To support the use of arbitration for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen. (Adopted August 1977.)

4. To support the voluntary use of arbitration so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and that arbitration panels should consist of one impartial arbitrator in "small" claims cases and three arbitrators - an attorney, a physician, and a layman in larger claims cases. (Adopted August 1976.)

The ABA is concerned about achieving a more expeditious and economical resolution of medical malpractice litigation. Voluntary alternative dispute resolution, for example, has gained acceptance as an alternative to litigation. The ABA recognizes the importance of the development and use of ADR methods other than full judicial trials for resolving legal disputes. ABA policy supports the "continued use of and experimentation

with alternative dispute resolution techniques both before and after suit is filed," so long as they assure that every disputant's constitutional and other legal rights and remedies are protected. Of course, such concepts have equal validity in litigation against any defendant, and no special justification exists for being applied only in cases involving medical professionals.

The use of voluntary alternative dispute resolution techniques is consistent with the relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends. Besides relieving court congestion and speeding up the conclusion of cases, these alternative dispute resolution procedures are often less expensive and less stressful than seeing a case through its normal trial path.

Thank you for giving us this opportunity to present our views to you.

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ENDNOTES

1 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

2 Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.

3 The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care." Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.

4 The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." Physician Payment Review Commission 1991 Annual Report to Congress, page 374.

5 Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol.327, No.21, Nov. 19, 1992, pages 1497-1501.

Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI Scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," The New England Journal of Medicine, Vol.327, No.21 Nov. 19, 1992, pages 1502-1506.

6 Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, No.3, Summer 1991, pages 51-69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physician Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

* Physicians and hospitals often benefit financially by delivering more care.

* Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.

* So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

7 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

8 Andrea Dubin, False Claims: The Relationship between Medical Malpractice "Reforms" and Health Care Costs, prepared for the Coalition for Consumer Rights, March 1993, at Page 2.

9 Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.

10 1989 Profitability Study (By Line By State) 1990 Profitability Study (By Line By State), 1991, Profitability Study (By Line By State), 1992 Profitability Study, (By Line By State), National Association of Insurance Commissioners, 1990, 1991, 1992 and 1993.

11 Martin L. Gonzalez "Medical Professional Claims and Premiums 1985-1990," Socioeconomic Characteristics of Medical Practice 1992, page 23.

APPENDIX A.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
February 11, 1986

Be It Resolved, That

(1) The American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The legal and medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

(2) Consistent with these goals, the American Bar Association adopts the following principles:

a. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

b. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

c. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

d. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

e. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

f. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

g. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

h. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

i. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

j. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

k. The use of structured settlements should be encouraged.

l. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

APPENDIX

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES

February 16-17, 1987
(Report No. 123)

Be it Resolved, That the American Bar Association adopts the following recommendations:

A Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the range of damages to be awarded for pain and suffering in a particular case.

C Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanction and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

b The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical norms (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to secure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of noncmanagerial servants or agents.

e To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

awards to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested proposals for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory serious practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

II Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office. May 1993. Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).

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Percentage of Increase from 1982 to 1990 in Personal Health Care Costs Per Capita, State by State

*1982 RANKING/STATE**	*1982 HCFA data**	*1990 LEWIN/ICF Estimates**	*% of INCREASE***
1 Massachusetts	$1,508	$3,031	101
2 California	1,451	2,894	99
3 New York	1,417	2,818	99
4 Nevada	1,380	2,757	100
5 Rhode Island	1,351	2,707	100
6 Connecticut	1,348	2,699	100
7 North Dakota	1,325	2,661	101
8 Illinois	1,308	2,619	100
9 Missouri	1,285	2,568	100
10 Michigan	1,281	2,569	101
11 Pennsylvania	1,273	2,536	99
12 Kansas	1,271	2,548	100
13 Ohio	1,247	2,493	100
14 Maryland	1,232	2,436	98
15 Minnesota	1,229	2,480	102
16 Hawaii	1,228	2,469	101
17 Florida	1,228	2,427	98

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
18	Wisconsin	1,219	2,449	101
19	Nebraska	1,216	2,452	102
20	Colorado	1,209	2,415	100
21	Alaska	1,187	2,367	99
22	Iowa	1,176	2,351	100
23	Washington	1,165	2,311	98
24	Oregon	1,165	2,312	98
25	South Dakota	1,154	2,322	101
26	Delaware	1,153	2,268	97
27	Tennessee	1,144	2,262	98
28	New Jersey	1,115	2,224	99
29	Arizona	1,112	2,211	99
30	Texas	1,110	2,192	97
31	Louisiana	1,106	2,185	98
32	Indiana	1,101	2,201	100
33	Maine	1,091	2,175	99
34	Oklahoma	1,086	2,139	97
35	West Virginia	1,057	2,088	98

1982 RANKING/STATE*	1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
36 Virginia	1,054	2,076	97
37 Georgia	1,048	2,072	98
38 Montana	1,036	2,059	99
39 Alabama	1,033	2,286	121
40 Arkansas	994	1,944	96
41 New Hampshire	986	1,981	101
42 Vermont	978	1,956	100
43 Kentucky	957	1,875	96
44 North Carolina	931	1,833	97
45 New Mexico	904	1,792	98
46 Mississippi	897	1,751	95
47 Utah	896	1,784	99
48 Wyoming	873	1,756	101
49 Idaho	868	1,726	99
50 South Carolina	857	1,689	97
U.S. Average	1,220	2,425	99

* *This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S personal health expenditures per capita averaged $2,255*

** *Rounded off to the nearest whole number.*

APPENDIX D.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
AUGUST 1988

Be It Resolved, That the American Bar Association supports the increased use of alternative means of dispute resolution by Federal administrative agencies consistent with the following

A. General

1 Administrative agencies should adopt alternative methods of dispute resolution for resolving a broad range of issues. These techniques include arbitration, factfinding, minitrials and mediation. The issues for which they may be employed include matters that arise in formal or informal adjudications, in rulemaking, in issuing or revoking permits, and in settling disputes including litigation brought by or against the government.

2 Congress and the courts should not inhibit agency uses of the ADR techniques by requiring formality where it is inappropriate.

B. Voluntary Arbitration

3 Congress should act to permit executive branch officials to agree to binding arbitration to resolve controversies. This legislation should authorize any executive official who has authority to settle a matter on behalf of the government to agree to arbitration, either prior to the time a dispute may arise or after a controversy has matured, subject to whatever may be the statutory authority of the Comptroller General to determine whether payment of public funds is warranted by applicable law and available appropriations.

4 Congress should authorize agencies to adopt arbitration procedures to resolve matters that would otherwise be decided by the agency pursuant to the Administrative Procedure Act ("APA") or other formal procedures. These procedures should provide that:

(a) All parties to the dispute must knowingly consent to use the arbitration procedures, either before or after a dispute has arisen.

(b) The parties have some role in the selection of arbitrators, whether by actual selection, by ranking those on a list of qualified arbitrators, or by striking individuals from such a list.

(c) Arbitrators need not be permanent government employees but may be individuals retained by the parties or the government for the purpose of arbitrating the matter.

(d) Agency review of the arbitral award be pursuant to the standards for vacating awards under the U.S. Arbitration Act, 9 U.S.C. §10, unless the award does not become an agency order or the agency does not have any right of review.

(e) The award includes a brief, informal discussion of its factual and legal basis, but neither formal findings of fact nor conclusions of law.

(f) Any judicial review is pursuant to the limited scope-of-review provisions of the U.S. Arbitration Act, rather than the broader standards of the APA.

(g) The arbitral award is enforced pursuant to the U.S. Arbitration Act but is without precedential effect for any purpose.

5 Factors bearing on agency use of arbitration are:

(a) Arbitration is likely to be appropriate where —

(1) The benefits that are likely to be gained from such a proceeding outweigh the probable delay or costs required by a full trial-type hearing.

(2) The norms which will be used to resolve the issues raised have already been established by statute, precedent, or rule, or the parties explicitly desire the arbitrator to make a decision based on some general standard, such as "justice under the circumstances," without regard to a prevailing norm.

(3) Having a decisionmaker with technical expertise would facilitate the resolution of the matter.

(4) The parties desire privacy, and agency records subject to disclosure under the Freedom of Information Act are not involved.

(b) Arbitration is likely to be inappropriate where —

(1) A definitive or authoritative resolution of the matter is required or desired for its precedential value.

(2) Maintaining established norms or policies is of special importance.

(3) The case significantly affects persons who are not parties to the proceeding.

(4) A full public record of the proceeding is important.

(5) The case involves significant decisions as to government policy.

C. Mandatory Arbitration

6 Arbitration is not in all instances an adequate substitute for a trial-type hearing pursuant to the APA or for civil litigation. Hence, Congress should consider mandatory arbitration only where the advantages of such a proceeding are clearly outweighed by the need to (a) save the time or transaction costs involved or (b) have a technical expert resolve the issues.

7 Mandatory arbitration is likely to be appropriate only where the matters to be resolved —

(a) Are not intended to have precedential effect other than the resolution of the specific dispute, except that the awards may be published or indexed as informal guidance;

(b) May be resolved through reference to an ascertainable norm such as statute, rule or custom;

(c) Involve disputes between private parties; and

(d) Do not involve the establishment or implementation of major new policies or precedents.

8 Where Congress mandates arbitration as the exclusive means to resolve a dispute, it should provide the same procedures as in Paragraph 4 (b) - (g) above, except that judicial review should be pursuant to the Administrative Procedure Act but with the courts bearing in mind the purposes to be gained by arbitration.

Senator HEFLIN. Mr. Corboy, in your testimony, you cite a study relative to the cost of the Medical Professional Liability System, to the overall Health Delivery System, of 1992 which was funded by the Texas Medical Association, the Texas Hospital Association, and the Texas Trial Lawyers Association, in which you say that their findings indicated that changing the medical professional liability system will have a minimal cost savings impact on the overall Health Care Delivery System in Texas. I just wonder how you got the trial lawyers and the doctors and the hospitals to jointly have a study?

Mr. CORBOY. I do not practice law in Texas, Judge, but my guess is that they sat down, just like U.S. Senators sit down, and they bashed it out. It surprised me, too, but rather than rely on that, may I respectfully suggest you rely on the Congressional Budget Office, which estimates in 1993 that there was less than one percent of total health care expenditures to compensate all victims of malpractice. We have a chart on it. Perhaps there is more susceptibility to accepting the Congressional Budget Office than there is the Texas trial lawyers group and the hospitals in Texas.

I wish I could answer that. I will call up my friend Pat Maloney down there and find out how they got around to doing it. I do not know.

However, the Congressional Budget Office affirms that figure of less than one percent, which we have supplied in a chart which is available to you, indicating that the cost of premiums for malpractice coverage in the United States of America at this time is less than three-quarters of one percent of total medical care.

If you folks decide, and I am sure you will—and by the way, the ABA is absolutely in favor of universal medical care, no matter what version you adopt—we believe everybody should have medical care available to them. I realize that is like being in favor of mom and the Fourth of July. But in the meantime, I want you to know that we are in favor of that.

It is going to be very difficult for you to pass any legislation—any legislation at all—that is not going to cost money. It is going to cost more than it does now. If there is universal coverage, it is going to cost people more. That is a given. If it does, the medical malpractice premium cost will be even less than three-quarters of 1 percent. There is no indication that medical malpractice premiums are going to go up because medical expenses are going to go up.

Senator HEFLIN. Well, these studies, of course, show the costs of that, but do not cover the issue of defensive medicine. Dr. Ginsburg, in your studies, have you come upon anything that would indicate what the cost of defensive medicine is; and the second question is will tort reform reduce the cost of defensive medicine?

Mr. GINSBURG. As far as the cost of defensive medicine, we have seen the studies that people have mentioned and appreciate how difficult it is to study, because defensive medicine is not doing things that have no value to the patient. That is one type of defensive medicine. Probably, the more important parts, quantitatively, are doing things which might have slight benefit to the patient but are very costly and would not be done except for the fear of being sued.

One thing I can say about defensive medicine and tort reform is that it is not clear what contribution tort reform might be to reducing defensive medicine. I think to really reduce defensive medicine, we have to go further than tort reform; we have to go to a more broadly reformed malpractice system.

But I do not think defensive medicine is the major reason for doing tort reform. I think there are a lot of other reasons. The system operates very inefficiently. It is very unpredictable. It is very expensive. And let me say that the costs of these malpractice premiums, you know, if I went to GDP, it would be an even small fraction, but these costs are substantial as a proportion of physician revenue. These premiums are about 5 percent.

And let us think about who pays these premiums. Basically, these premiums are paid by those who pay for medical care—individuals, their employers, the United States and State Governments who pay for medical care, both directly and through the tax system, because health insurance premiums are deductible as well as malpractice premiums are deductible.

So when we talk about tort reform, we are really talking about is this system too expensive, and we are trying to weigh our interests as those who pay for medical care through various mechanisms, as well as our interests as potential injured patients who would be plaintiffs. And I think we could do a lot in tort reform to be worthwhile, even if it did not reduce defensive medicine.

Senator HEFLIN. Dr. Niles, in regard to the practice guidelines that might be developed by which the physician would be able to demonstrate that his professional conduct or treatment complied with the appropriate practice guidelines and would not be liable for medical malpractice. On the other hand, would you be in favor of allowing a plaintiff to introduce the guideline and show the noncompliance as a medium of establishing malpractice?

Dr. NILES. Well, Mr. Chairman, let me first say that I would like you to come into the operating room with me and ask some questions about doing a C-section. You are asking me some legal questions, but let me just try to respond.

First, in the State of Maine, there is a demonstration project under way that will use practice guidelines, and that study is about 2 years into its process. But obviously, as you have said, if the defendant can use those practice guidelines, to me, just using common sense, the plaintiff would also be able to use those guidelines if they were not followed.

Mr. Chairman, could I make some comments at this point on some of the statements that have been made earlier?

Senator HEFLIN. Certainly. Go ahead.

Dr. NILES. I appreciate it. I do not want this to degenerate into a doctors/lawyers cat fight, but I think that some of the comments that have been made are totally inappropriate.

First of all, to suggest that the reason why we do not have tort reform in the District of Columbia is because we have negligent doctors is totally inappropriate and uncalled for. You said that.

The second thing, that the reason why we do not have tort reform in the District of Columbia is that we have——

Senator HEFLIN. I believe he said that that "could" be a cause.

Dr. NILES. Thank you for clarifying that, but I do not think it even should be considered as a cause. The reason why we do not have tort reform in the District of Columbia is that we have three trial lawyers on our city council. That is the reason why we do not have tort reform.

I just want to make some interesting comments, personally. I have paid over $500,000 in the last 10 years in malpractice premiums. I had to deliver babies, perform surgery, see patients to earn that money—and it might be deductible, but I had to earn it in the first place to be able to deduct it. We have a physician-owned insurance company here in the District of Columbia because no insurance carrier will come to the District of Columbia because they cannot render insurance at the levels. We had to form our own physician company, so our rates are as low as possible.

I personally have had one case in 24 years. That particular case was in 1982, and the judgment was less than $50,000; and I paid over $500,000 in premiums.

Mr. Corboy, on the other hand, according to a Forbes article published in 1989, they estimated his income to be $5.7 million. Now, I have not made $5.7 million in my entire lifetime, nor will I make that amount of money—and that was in 1 year.

I think this is more an issue of trying to maintain the status quo for trial attorneys versus the fact that physicians in this country are providing excellent care in spite of some of the points that have been raised today about patients being killed every 6 minutes by doctors. I do not know where those numbers came from. I work every day, and we do not see that kind of mortality in our hospitals. I do not know where that number came from.

But in the United States, people come from all over the world for care, and I think that our system as far as providing medical care bars none in this world. No one would want to deliver their babies in the Caribbean, the United Kingdom, Canada, or Mexico. They want to deliver them here in the United States. And I think it is unfair that the trial bar continues to want to maintain the status quo.

Physicians have found uniformly that we are not playing on a level playing field. We are asking for some relief, and we are asking for some change in the tort laws that have not been changed over time. My personal view and my experience here locally in the District of Columbia is that we cannot get that at the local level, and we need some Federal help for that situation.

Senator HEFLIN. Senator Grassley?

Senator GRASSLEY. I think it would help to quantify to some extent the three-quarters of 1 percent that you used, Mr. Corboy, in this sense, that if we have a trillion dollar health care system—and it doggone close to that; it goes up $8 billion every month—that is still $7.5 billion, and that is a heck of a lot of money.

And on another point, I think you asked a legitimate question at this end for us, when you said 70 percent of doctors win their lawsuits, so what do we want.

I think what I am looking here in tort reform is that doctors make a decision not to practice a certain medicine based on conditions other than the cost of medical malpractice insurance. I do not know how it is in the large cities, but I know in the rural areas

of America, because I have had doctors tell me this, and I have had nondoctors who are interested in the delivery of health care in rural America say that particularly in the delivery of babies, some doctors, particularly when there is a greater-risk baby being delivered, just do not deliver because they cannot afford the insurance because there are not enough babies to spread the cost of it over. There are other factors that may be involved, but that is one very real area where we have a problem in rural America.

My first question would be to Dr. Ginsburg on a point that I think you were making when you were talking about your short-range and long-range recommendations. One of your long-range recommendations included a redesign of the malpractice system so that those who suffer preventable medical injuries get adequate compensation. You propose an administrative system to handle this. Are you basically putting this in the area of no-fault, similar to what we have for workmen's compensation?

Mr. GINSBURG. That would be one version of it. You could use a number of different standards other than negligence in these systems. I think no-fault would be the most extreme where, whenever someone is injured in the course of medical care, they would be compensated. The standard of preventability or avoidability is somewhat closer to what we have now, where that would not include certain risks to medical care that are well-understood and cannot be avoided, so it would pay somewhat fewer claims.

Another standard would be the accelerated compensable events, where you would identify certain injuries and pay them without bothering to establish fault.

So I think that all of these standards have potential to separate the establishment of compensation from the quality control system, and I would like to recommend one now, but I would not want to go forward until there has been more development and experimentation for them.

But in a sense, the real concern is that we feel the current tort system does not do a very good job of improving the quality of care; that there is much better potential using other mechanisms, and if we could separate the quality from the compensation system, I think there is a lot of potential to improve the system for everybody.

Senator GRASSLEY. You also spoke about the need for limits on pain and suffering and punitive damages and things like that. Is it your view—and I do not think you said this strongly if it is your view—that we do not have reform of malpractice unless those limits are included?

Mr. GINSBURG. Yes; I think having limits is a very important part of reforming malpractice. I think it is not only the central part of current tort reform, but I think it is critical for the future systems as well. We have worked somewhat on the notion of having a schedule of payments for noneconomic damages, in a sense to get more consistency, and the schedule need not be a single number for every type of case; it could be a range. You could give some discretion to juries. But I think the system very much needs some of the consistency and basically, our representatives or the people that they designate talking over and thrashing out what the limits

should be rather than determining it on a jury by jury basis each time.

Senator GRASSLEY. You were here when the Chairman and I were discussing—or was it Ms. Lebow—whether or not the malpractice, which their program does not include, ought to include medical devices, drug companies, and respective manufacturers. Do you think that they should be included as well?

Mr. GINSBURG. Frankly, I have not given it much consideration. I understood the argument about the real problems——

Senator GRASSLEY. Let me ask Dr. Niles, Ms. Wittkin, and Victor Schwartz if you think they should be included—medical device manufacturers, drug companies, et cetera.

Ms. WITTKIN. Our position is that they should not be included as part of the tort reform?

Senator GRASSLEY. Dr. Niles?

Dr. NILES. I cannot really respond to that, Senator. I am not qualified.

Senator GRASSLEY. Mr. Schwartz?

Mr. SCHWARTZ. I think if you just took an example, you would see why they have to.

First, if there is an ADR provision in the bill and you have a case brought in Federal court, the parties that are in the case are likely to be in many instances more than just a hospital and doctor. I submit if reforms are made in this area, it is almost certain that every possible defendant, even if somebody is thought of as being 1 percent responsible, is going to be included. And what happens under our law, whether we like it or not, is that 1-percent-at-fault party will bear 100 percent liability. So let's just get it specific. If you have a $1 million award—and the way caps work in many States, and they probably should work this way—the jury comes back with the award. The jury does not know about the cap. If the jury knew about the cap, the thought is that often what is supposed to be the ceiling becomes the floor. So statutes say the cap is $250,000; the jury is not informed about it; the jury comes back with a $1 million award.

There are $750,000 sort of wandering around. Now, that has got to end up somewhere. Under the rules of joint liability, the party that is 1 percent or 5 percent or 10 percent responsible will pick that up. And if you were a plaintiff's lawyer and doing your job, you would make sure that every possible defendant was included in any action if there were limits against one particular defendant. So that is why, unless you just want to shift costs as compared to save costs, all possible defendants—and there may be some we have not even thought of.

For example, until very recently, people had not thought of people who supply materials to medical device manufacturers—plastics, resins, and things like that. Senator Lieberman held a very interesting hearing on that last week. They are going to be included, too. And the bottom line is that if these things are going to go forward, all defendants should be included, regardless you cannot name them, because it is going to be left to the future imagination and vigor of people who represent claimants to figure out who should be included, so, therefore, the legislation should encompass everybody who is a defendant.

Senator GRASSLEY. This is my last question, Mr. Chairman and Senator Hatch. It is coming from a little different perspective, and it may sound like I am advocating the ability to sue. But it is something that comes out of managed competition that I want to ask you about.

It is not clear from my perspective that managed competition systems, which are the centerpiece of most of the comprehensive reforms around the Hill here, will solve the malpractice crisis.

On the other hand, it may lead to less defensive medicine. If a doctor is not going to paid for a particular test or treatment, then the doctor may not give the test. But couldn't this lead to more lawsuits against health care providers for failing to pursue adequate care? Such claims could fall within the negligence standard that governs malpractice cases which "are conduct that falls below the standard established by law for protection of others against unreasonable risk of harm."

Could either Dr. Niles or Mr. Schwartz comment?

Dr. NILES. I think the issue of managed competition and managed care programs will have to be looked at. I think that, hopefully, these managed care programs will look at the guidelines that are developed and will adopt them and will not disagree with them.

The problem we run into that we are experiencing now with some of the managed care programs is the length of stays in hospitals. The stay for an obstetrical delivery is now one day for vaginal delivery. There are some programs in some of the Western States where it is 12 hours. Some are looking at the possibility of alternative birthing centers as a way of delivering babies.

If these managed care programs in their effort to provide cost containment then impinge on the physician's ability to provide safety and proper care, yes, it will expose us more to possible action being brought for our failure to provide the proper care, because they will be setting up mechanisms that may be divergent to what we are used to doing. But I would hope that in that process we could be able to clear the air, so to speak, on those particular issues and let them follow the appropriate guidelines and still be able to maintain their cost containment concern.

Mr. SCHWARTZ. I would just add that they would be added as defendants to any malpractice suit, especially if limits are placed only on certain parts of the Medical Health Care Liability system.

Senator GRASSLEY. Thank you, Mr. Chairman.

Senator HEFLIN. Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

I welcome all of you to the committee, and I appreciate the testimony you have given. This is a very serious and difficult set of problems for us because almost everybody agrees there needs to be some reform, but nobody can quite come up with exactly what type of reform there needs to be.

For instance, the Office of Technology Assessment published a report last year that suggested that only damage caps and collateral source rule changes have had a clear effect on the direct costs of medical malpractice, and they further suggested that even these changes have not resulted in much in the way of cost savings; you know, that any cost reductions created by those reforms are modest in light of overall health care spending.

And so they suggested that we investigate the indirect costs or what you have been referring to here as defensive medicine. And estimates of those costs vary widely, too. The AMA estimate that there is about $30 billion this next year in defensive medicine. That prompts a number of people to say if they admit to $30 billion, can you imagine how much it must really be?

When we talk of defensive medicine, I would like to even delineate that further and say unnecessary defensive medicine, which is propelled and caused by the fear that doctors are going to be sued for medical liability, and not just doctors but health care providers in general.

Now, I would like to ask each of the witnesses to tell us what you feel, whether you believe that defensive medicine adds substantially to the costs of health care delivery in this society, and if so, what would you recommend? Why don't we just go through each of the panelists? If you could make your answers fairly short, I would appreciate it.

Ms. WITTKIN. Senator, my organization was briefed by the Office of Technology Assessment in New York State as part of Governor Cuomo's Health Care Advisory Task Force a few weeks ago, and they spoke about the findings of the soon-to-be-released defensive medicine study that they have been working on. What they found was essentially that defensive medicine, whether it is negative defensive medicine or defensive medicine in general, is extraordinarily difficult to quantify. But they did criticize very strongly both the AMA and the Lewin studies, the studies that we are talking about right now, as being thoroughly unreliable and subjective, not based on any empirical evidence. And I think that that is one of the problems.

They further said that most of the practices that we label defensive medicine are, in fact, sound medical practices and that they do have a benefit for the patient, and that you cannot ignore the fact that there is a direct relationship very often to reimbursement and whether or not somebody has procedures done. And when we look around this country at some of the abuses that have taken place in clinics and labs that have been owned by physicians, we can see a direct correlation between excessive and unnecessary tests and procedures and a financial gain.

They further said again—I know they said that in their earlier report about certain things reducing malpractice premiums. They said it again in this defensive medicine report that liability reform will, in fact, reduce malpractice premiums to some extent and allay some of doctors' fears, but will really have no impact on defensive medicine spending.

Mr. GINSBURG. I have an appreciation for how difficult it is to estimate defensive medicine, and I know the studies that have been criticized, the criticisms have been valid that nobody has been able to do better. And I think we are going to have to proceed with a lot of uncertainty as to the magnitude of defensive medicine.

A concern I have is that I think truly reducing defensive medicine—and I would add into this having physicians feel free to follow new practice guidelines as they are developed because that is one of the directions that medical care is going. I think there is a cloud that is going to limit them, and I think to deal with it, we

have to start talking about different standards other than negligence to more substantial changes of the malpractice system to get to the point where physicians are not restricted in what they think is good quality care.

Senator HATCH. You seem to be saying that we need to move to a system of guidelines in specialties and subspecialties, which could alleviate medical liability if followed.

Mr. GINSBURG. Actually, I think as guidelines become more important, I think they are going to help in the malpractice system, because it is going to be easier for both plaintiffs and defendants to establish what a standard of care is and in a sense might be a good substitute for a lot of expert witnesses.

Senator HATCH. Can we create a system of standards across the board for both general and specialized practice of medicine and health care services?

Mr. GINSBURG. Well, I think we are at the point where the system is developing on its own. Practice guidelines are being used in cases. I am not sure that we are ready to codify them, to have a special safe harbor for guidelines, until we have more experience with how they are used in the system. And it may never be required to actually codify these are the guidelines that count. The guidelines that are developed in a responsible manner and certified by leading organizations I think are going to have important standing in malpractice suits.

Dr. NILES. In response to your question about defensive medicine, I think that, again, it is almost like an elephant; you know, depending what end you are at, if you touch the trunk or you touch the tail, what it really means. I think what I see in being in the trenches is that what happens is that in the response to concerns about providing care, there are times when physicians will order additional testing—and I would have to beg to differ that it is for financial gain—to try to reinforce or reconfirm their diagnosis.

For example, if I am treating a patient that is severely hypertensive and pregnant, I may refer that patient to a maternal-fetal medicine specialist for a consultation, where I may have the same expertise in terms of my experience and time, but I will refer that patient for a maternal-fetal medicine consultation to try, in essence, to give the patient another opinion and view as to how to manage this patient.

I may not necessarily have to do that, and if someone would want to label that as defensive medicine, then I guess that would be an example.

Senator HATCH. I do not think they are talking about that. I think they are talking about the average soft tissue injury, just to give an illustration, that goes in, the old standard of practice basically was take these muscle relaxants, get as much rest as you can, come back in two weeks and we will see where you are. If it doesn't get better, it is not just a mere strain. If it turns out to be a sprain, then they will say, well, maybe we had better do a CT scan.

Dr. NILES. Well, I do not think we can do that today.

Senator HATCH. If that does not work, then maybe we had better do an MRI. And by the time you get through, what used to be a $50 bill is $2,000.

Dr. NILES. I do not think we can do that today in this climate, and maybe that is part of the issue. If I see a patient with pelvic pain and she has missed a menstrual period, I am going to have to rule out an ectopic pregnancy, I am going to have to rule out missed abortion, I am going to have to rule out threatened abortion, I am going to have to rule out acute appendicitis. I am going to have to rule out all those things before—I cannot give her two aspirin and tell her to call me in the morning. I am going to have to review those things, and if that is defensive medicine, then that is what we are dealing with.

Senator HATCH. I do not consider that defensive medicine.

Dr. NILES. Well, anything past that—again, it is kind of hard for me to define because I have not necessarily seen the studies of what we are describing. But I think there is an element of a defensive process. An example, again, is a C-section, the issue about doing cesarean sections. I think that what has happened, physicians are rarely sued for not doing a cesarean section. They are sued for doing a section not soon enough. This is what we see. We see the process where a patient was admitted at 3 o'clock in the morning and the section was performed at 7:00, the idea being that some expert will come in and say, well, had the section been done at 4:30, then the baby would not have been brain damaged.

So physicians are under the gun, so to speak, to look at these issues, and many times with cases of potential nonreassuring fetal monitoring, a C-section is performed and possibly another picture in time may have prevented that—may have been a situation where that section may not have been performed. So if that is defensive medicine, that is another example of what you can look at in terms of increasing costs.

Senator HATCH. Victor?

Mr. SCHWARTZ. Well, your question is a difficult one because you actually have to get into the mind of a doctor when he or she is making a decision. And no matter how many surveys or how much data you collect, it is going to be very difficult to find out: Has the test been ordered because it is necessary, or has it been ordered because they really are worrying about exposure to liability?

I think you have gone to some of your own personal experience, Senator, and I submit that all the Senators have had experience with medicine, as I have had, as patients. We are not doctors. We ought to listen to them, find out whatever information we can about this.

I think you can try to eliminate any data that comes from doctors where there is self-referral to try to get rid of a category that Mr. Corboy addressed where it might be economic gain that is motivating the person. But there is information from doctors who are ordering tests or doing tests where they are not making a profit from it, and look at that and make a judgment. I think that is what it is going to come down to.

If you get into a data war, you are going to be here to the year 2000, and I think that you cannot do that here. You have to make at some point a common-sense judgment about whether this occurs and whether it is a problem.

As far as solutions are concerned, I think that there are a few, but each one has to be approached carefully. The practice guide-

lines subject has been discussed somewhat. I think pilot studies to learn more about them are worthwhile. I do think, in answer to your question, Senator Heflin, to another witness, that if they are established, what is sauce for the goose is sauce for the gander. If a person does not comply with them, that is a presumption that they may have been at fault, although they may have good reasons, medical reasons why they did not do so and they ought to be able to explain them. But at least it provides some predictability.

Anything you do with damages, if there are limits, does provide predictability, and people are going to be less afraid of exposure if there is some type of limit on damages than they are if there is no limit. But if you do that, you want to make sure that you have not created a world where you are encouraging wrongful behavior that is currently addressed by the tort system.

That is why California is a pretty good laboratory. You have had a proposal out there for some time. It is one of the best labs we have had to find out what happens when you put some of these limits in place. Has it reduced defensive medicine? Can we find out? Has it resulted in more malpractice being committed? That is something and it is a place where we can look.

Senator HATCH. Mr. Corboy?

Mr. CORBOY. Let me read from a report of the CBO when it was trying to analyze the effect of various types of tort reform on what is—I think we are all using the term in a pejorative sense, and maybe we should not, "defensive medicine." Here is what the report says if tort reform came of various types:

> Much of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of the "defensive care helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to medical malpractice reform."

Now, specifically with reference to caps, I cannot imagine a doctor saying to himself or herself under the most extreme circumstances if a patient came into them and said I would like "x" care, and the doctor said, well, I am going to analyze this and I am either going to—and perhaps I am being pejorative now—I am either going to engage in defensive medicine here or I am not. Now, let's see this person's status. It is a housewife that has no loss of earnings, or it is a student who has no history of earnings, or it is a retired person who is not working at all. I know, said the doctor, that these folks can only whack me for $250,000 and, therefore, I am not going to engage in defensive medicine? That does not make sense.

By the same token, if a patient comes into him who has a large earning power and has also a very serious injury of a psychic and physical nature, is the doctor then going to say, well, because the damages are only going to be $250,000 for the noneconomic losses but they are still going to be large for these other losses, am I then going to engage in defensive medicine?

What I am trying to say is that I do not believe that any reform which limits or takes away the rights of people who have been damaged by malpractice—you have to make the basic assumption first. They are not going to recover, and they are not going to re-

cover anything unless they are hurt. So I do not know how the admonition written into the law of we are not going to be responsible for more than $250,000 in noneconomic damages is going to change the practice of a doctor. He either is or is not going to engage in defensive medicine.

Senator HATCH. All right. It has been estimated by the RAND Corporation, for instance, that more than half of the more than $9 billion which will be paid this year in liability premiums will go to attorneys for fees and expenses. More than half. Only about 40 percent of those premiums go to help injured patients. Furthermore, it is estimated by the GAO, the General Accounting Office, that 43 percent of insurers' defense costs are paid in cases where the defendant wins. In other words, where the doctor wins.

Now, it seems to me that even if we assume that the system worked well in achieving the right results, which is not clear, the transaction costs are quite high. My question is: Do you not all agree with that? And how can we direct some of the billions we use for lawyers back to patients and into the Health Care System? That is a question a lot of people have.

Why don't we start with you, Mr. Corboy, and go the other way?

Mr. CORBOY. Why don't you answer first?

Mr. SCHWARTZ. Well, no. You moved the chair here, so why don't you go first?

Senator HATCH. I have enjoyed this interaction, by the way.

Mr. SCHWARTZ. It is only 30 years we have known——

Mr. CORBOY. I am looking for the thinking time that lawyers sometimes seek. Could you tell me specifically your question? I am serious. I did not——

Senator HATCH. Well, specifically that an awful lot of money is going for lawyers and not enough back into the Health Care System, and that literally only 40 percent of these health care premiums really benefit patients, where better than half are benefiting lawyers. And, unfortunately, that hurts the legal profession, it hurts the medical profession, and in the process is not helping the patients. It is one of the big arguments against the wide open tort system, the Medical Liability System that we have today.

Mr. CORBOY. Well, you know, there are a lot of workmen's compensation lawyers in the country that are making a living.

Senator HATCH. Sure.

Mr. CORBOY. There is no tort required at all. If lawyers—the only way to inhibit——

Senator HATCH. Then maybe we should move to a system of no-fault.

Mr. CORBOY. I do not think doctors want that. It may well be, but I do not think they want that, and I do not think insurance companies want it.

Senator HATCH. Sure doctors would want it. If it took away the onus of potential loss of their reputation, in a no-fault system——

Mr. CORBOY. Their reputation is still under scrutiny if you go to a doctor and you are injured and you get paid for it. The person that walks out of a——

Senator HATCH. Not nearly as much as with large verdicts in open court.

Mr. CORBOY. Pardon?

Senator HATCH. Not nearly as much as with large verdicts in open court.

Mr. CORBOY. That is another statistic——

Senator HATCH. Where the doctor has got to be hauled down to the courthouse and taken over the coals by you and me and others who are attorneys.

Mr. CORBOY. There is an organization called the National Insurance Consumer Organization that found in 1991 that $2.7 billion were paid out in claims, and the actual premium payments in 1991 were $4.9 billion, $5 billion, approximately. Now, while it is difficult to ascertain the amount of the moneys that lawyers got there, you have to keep in mind that that $2.7 billion was invested by those insurance companies, as they have a right to do. That is why they are in business.

So I respectfully suggest they paid lawyer's fees out of money they made on the investments. That is where the lawyer's fees got paid from. And, by the way, they are entitled to do that.

Senator HATCH. Sure. Mr. Schwartz?

Mr. SCHWARTZ. I think the data that you cited is good data in terms of how much the present system is taking out of——

Senator HATCH. It is far more accurate than the data you just cited, Mr. Corboy, because it is RAND and because it relates to the issue at hand. But be that as it may, it is still a hefty amount that is for lawyers not for——

Mr. SCHWARTZ. On both sides of the aisle. I noted that many of the proposals have ADR's in them, and that has become very popular now. It is pop. I submit that before you subscribe to a particular form of ADR that you have good information about whether that was just an add-on and adds to your legal costs or whether it really saves it.

It is my understanding—and I will submit some information to the committee——

Senator HATCH. Unless it is binding, it is going to add to the costs. There is no question about it.

Mr. SCHWARTZ. And then it would be argued that that is unconstitutional and you are taking away people's rights. So you have to bite the bullet one way or the other. There is the Northern California System that has been used called early neutral evaluation, and my understanding is that without limiting people's rights, it has helped reduce legal costs. And I will submit some material to the committee about that.

There is no doubt—I have been in practice now a while—that the more predictability there is in the system, the less lawyer crunching there is, whether it is on the merits, good or bad. If there is more predictability in the amount of pain and suffering damages, it is easier for me and my adversary to agree on a resolution and settlement.

Every addition of uncertainty in the system, including what the rules of law are, means that we are more likely to go on and on and on and on, me running my little clock. It is like a New York taxicab. It runs even when I am sitting still. And the legal fees on the other side are going to be very substantial.

I think that it is important for lawyers on both sides—and Mr. Corboy does this, but not everybody does—to let their clients know

in the beginning of a case what it is like, what it is going to take, so that that client can make an evaluation of whether that 33⅓ percent fee is going to be fair in that particular situation. And the more information going to the customer, I believe, will substantially help bring a market solution to excessive fees in our system. It really is not done, Senator.

There was an estimate made, not in this area but in another, where fees from victims are $2,000 to $5,000 an hour, documented, and the clients do not know it. And I think the time has come, and this Congress can help in this area. It does not restrict anybody's rights to sue. It does not limit somebody's access to a lawyer. And it will help reduce costs, as will some prediction in the rules of law that you have.

You know, it is from another area, but it does suggest all the unnecessary folderol that goes on. If you pick up a step ladder, you are going to read the top, all the way across, all the way down the bottom. That stuff, why is it there? You know, over the weekend I was at Hechinger's, and one man was reading "War and Peace" and another a step ladder, and the man is still reading the step ladder; the other guy finished the book first.

Doctors are going to be engaging in a lot of things because they do not know what the rules are. Lawyers are going to be running their clocks because they do not know what the rules are. So to the extent that you can stabilize the system and do it fairly, not where there is felt harshness, arbitrariness, you are going to reduce the system. Early neutral evaluation may help, or any other ADR that has proven to work.

Finally, disclosure of information about fees will work in the long run to reduce legal costs that are very, very substantial now.

Dr. NILES. In response to your question, I think that the information that has come out of California—and with their program, they do have a sliding scale in terms of their reimbursement for attorney's fees based upon the judgment. I think if it is over $500,000, it is 15 percent, or whatever the different numbers are. And I think that is an example that you can look at to respond to the sliding scale concept, and I think that is reasonable.

Physicians have a set fee no matter whether we deliver a baby or do a C-section. We have the same reimbursement that has already been set by the carrier. We do not get any more for any different, so I do not see any reason why lawyer's fees could not be set up on a sliding-scale basis based upon the amounts, particularly in the experience with California.

Mr. GINSBURG. Senator, I think you described the issue very well as far as trying to make this malpractice system more efficient so that more of the resources that go into it get paid out as compensation to injured patients. This is something, this inefficiency of the system, that perhaps we could afford in the past, but as medical care has become a larger part of our spending and as malpractice has become a larger part of medical care spending over time, we are talking about much bigger resources.

I think the single thing that could do most perhaps to reduce the administrative costs in the system would be reducing the uncertainty over the outcomes, that if we had a schedule of noneconomic damages and there was a lot more certainty as to what happens,

we would find fewer cases actually having to go to trial, more of them being settled, because both sides have a good idea of what would happen in a trial.

I would say that perhaps most of the cases that go to trial are evidence that the system is not working well. It is because there were such different projections by the plaintiff and defendant as to what would happen in a trial that it had to go there.

Ms. WITTKIN. I would agree, Senator, that it is important to find a way to make sure that as much of the resources that are in that system find their way to the victims and their families. And some of the suggestions and recommendations that we have made and submitted we hope will lead us down that path.

One of the problems with the administrative costs of malpractice and the liability system right now is the fact that there is usually not a statute of limitation for the disposition of the case, which means that cases can drag on 8 or 10 or 12 years in most States. And what we are calling for is a variation on what exists in California, actually, which is in California a 5-year statute of limitations for disposition of all cases once they are filed. We would suggest a 3-year statute of limitation for the disposition of those cases once they are filed.

Senator HATCH. Being imposed on the courts, you mean, to get the cases resolved?

Ms. WITTKIN. That is right, in every State, so that once a case is filed, exactly, it must move through the court and go to trial within 3 years and be resolved in 3 years.

The other part that we have difficulty with is every time we heard discussions about lawyer's fees, all we hear about are plaintiff attorney fees, and we are not hearing anything about the exorbitant and astronomical hourly fees that the defense attorneys get. And if you are looking at why the costs of the system continue to go up, you have got to look at that also as a culprit, because as long as there is no cap on what defense attorneys get, there exists that financial incentive to drag a case out forever. And that is usually what happens. So we would also suggest that this committee take a look at some sort of imposition of caps on defense attorney fees as well so that it is a more equitable system.

Again, I think you can probably resolve a lot of the transactional costs by having an alternative dispute resolution system that actually works, and one of the things you said earlier was that it would have to be a binding system. Senator Kennedy has in his new health care bill a proposal under alternative dispute resolution which creates a special unit that is actually binding, mandatory arbitration for low-end cases, cases under $100,000, so that many of the malpractice victims that are currently locked out of the system or caught in this system for years will be able to move through that system much more quickly, and that should certainly reduce some of those costs.

With respect to the 43 percent of costs of cases being attributed to defense wins, I believe you said, there is a wonderful study that was done by the American College of Physicians last year that I guess was published in the Annals of Internal Medicine. It is a 15-year study of one of the biggest malpractice insurance writers in the State of New Jersey, and it is a doctor-owned company where

cases were not settled, or could not be settled without consent of the doctor. So it is a very good example.

What the American College of Physicians found was that while maybe 5 percent of the cases that you could consider defensible were won by plaintiffs at trial, 58 percent of cases that a peer review team within this malpractice group determined were indefensible, no questions asked, were won by defendants at trial. So the fact that 43 percent of the money goes for defense verdicts is somewhat misleading, and I would suggest to you that we need to be very concerned not really about frivolous lawsuits on the plaintiff end, because most suits that get opened get opened initially to preserve somebody's right to sue, and according to this New Jersey study, 67 percent of the cases that close without payment close before discovery is finished.

So they are not frivolous cases that drag through the system, and I also think that is a mischaracterization of what most of these cases are about. It is a process of researching, of identifying, of getting expert opinions, and making a determination about the viability of the case. But I do think we need to be very concerned about how frivolous lawsuits on the defense side, and I would like to see the committee try to address that.

Senator HATCH. Well, this has been interesting. There are many other questions I have, but I have kept the chairman long enough. I just want to personally thank each of you for appearing and giving us the benefit of your expertise.

I have to say there is no simple solution or set of solutions here. The more I look at it, you know, the more difficult it is to decide what is the best remedy. I think that lawyers play a very significant and noble role in making sure that compensation is given in cases that deserve it. Yet having tried these cases on both sides, I have to say there are an awful lot of frivolous cases brought where an awful lot of big verdicts are given that are simply unjustified.

There are some, as you have cited, that are brought where there should have been awards and none is given. The system really is not working very well, and then I have to say I have tremendous respect for Dr. Niles who, day in and day out, is in this District doing the very best he can and who ultimately, if malpractice insurance premiums keep going up, is going to quit delivering babies, to the detriment of the women in this area, because he just cannot afford to do it. You can only deliver so many a year, and you can only charge, as you said, according to the schedule. You just cannot afford to do it after a while.

That is happening all over the country, and I do not know what the answer is. All I can say is that something needs to be done. And yet I know that Mr. Corboy, who, yes, makes a lot of money as a lawyer—some estimate he made as much as $8 million last year. He has got to be one of the leading lawyers in this whole country.

Mr. CORBOY. Do not tell my wife that. [Laughter.]

Senator HATCH. The reason he makes that is because he is very good and he gets good results. And I have to differ with you, Victor, on this. People do not care if they pay 33⅓ percent before trial and 40 percent if they go to trial if they know they are with a good law-

yer who is going to get them a good result, and especially on a contingency basis where they do not get anything if they do not go to a good lawyer.

So, I believe there are valid reasons for lawyers charging a third, or if going to trial, as high as 40 percent. Generally the lawyers who can do that are generally the ones that get the best results for their clients, too. I have had that experience.

But something has to be done because the system is not working well, and I submit to you that defensive medicine—I am talking about unnecessary defensive medicine, like treating a common cold, by putting a patient through a battery of blood tests and cardiovascular tests and respiratory tests at a cost of $200, $300, $400, $500 for something that should not have cost more than $20, $25. We have got far too much of that going on. Unnecessary defensive medicine is, in my opinion, in the hundreds of billions of dollars. And it is driving up the costs of this whole system, to a degree.

Now, how you get that reduced, I agree partly with Mr. Corboy. If we put in a system of caps, binding arbitration or alternative dispute resolution, limitations on attorney's fees, we will not have much in the way of reduction of health care costs initially. The only thing it might do is get us ultimately to a point where we will have standards of practice developed where doctors know what they have got to do, live within those standards, and do it to avoid liability and give good care.

Now, if we move towards the President's program in health care, we are going to have standards of practice because these HMO's and these managed competition entities are not going to allow excessive medicine. In fact, they may not allow needed medicine. That is what a lot of people are concerned about.

So I guess what I am saying is that we are at the rug-cutting time. Tomorrow in the Kennedy Labor and Human Resources Committee we will be discussing medical liability, that particular chapter. And I have to say that I do not have the real answer yet as to exactly what has to be done, but something has to be done to get the system to work a little bit better than it is. So I would like each of you to think about it and give us your ideas as much as you can.

A lot of us are not here trying to be on one side or the other. We want to do what is right. I see the efficacy of having lawyers out there fighting battles for society, making sure that the wrongs of society are remedied, and playing a noble and significant role in seeing that that happens. On the other hand, I see voracious lawyers out there bringing cases that are not proper, where they are getting judgments that are not justified, and over-utilizing the system and really not rendering noble service by making sure that liability is assessed against those who really have perpetrated actions against victims.

So we need some help here; I do not know what the answer is. All I know is that there are thousands and thousands of cases filed that do not deserve to be filed, that the medicine is not an exact science, that there are bad results even though doctors have used the highest standards of medical practice, and they should not have to have liability for that when they do. And maybe a no-fault system is the way to go. I do not know. Maybe a combination of no-

fault, alternative dispute resolution, or your California system of early neutral evaluation that you were discussing, which sounds to me like a good system of pretrial conciliation, which is all that it is. Maybe we just ought to keep it wide open and let it go the way it is, and the doctors will have to put up with it.

I do not know what it is, but I would sure like to have the best advice that any of you or all of you can give, because we are going to have to resolve it one way or the other. There are 900 medical liability suits filed a day in this country, and most of them are frivolous, or a lot of them are frivolous. Many of them are very serious cases that should be filed.

So, with that, I apologize for taking so much time, Mr. Chairman. I appreciate your graciousness towards me, but it is a matter of great concern to me. I think it is much more significant than the people who are writing our health care reform bills think it, much more significant than that. And yet there is no simple or easy answer to it, and so we have got to get our minds together to see what we can do to resolve the problems without taking away the protections that the system really needs.

Thank you.

Senator HEFLIN. Thank you. We appreciate your testimony.

[Whereupon, at 12:12 p.m., the subcommittee was adjourned.]

APPENDIX

Additional Submissions for the Record

Prepared Statement of The American College of Physicians

MEDICAL LIABILITY REFORM

The American College of Physicians (ACP) appreciates this opportunity to testify on the issue of medical liability reform. With a membership of more than 81,000 physicians who practice internal medicine and its subspecialties, the College is the nation's largest medical specialty society. Internists provide more medical care for adults, and more care for Medicare patients, than any other specialists.

The ACP is a strong supporter of *comprehensive* health care reform because we believe the multifaceted problems of the current system must be addressed in an integrated fashion. It is critical that meaningful medical liability reform be a component of health reform legislation. We hope that today's hearing is a signal that you agree, and we appreciate the opportunity to present our recommendations.

Our nation's malpractice system does not work—for injured persons or physicians. Lawsuits are time-consuming and expensive for both sides, and many victims of negligence don't receive timely and adequate awards.

Physicians feel threatened by the potential for litigation and often believe they must perform procedures merely to protect themselves from liability. In a 1992 Gallup poll of general practice physicians, 93 percent of those surveyed said that the threat of medical liability suits causes them to order tests they might otherwise consider unnecessary. This risks harm to patients, causes the physician-patient relationship to suffer, adds to health care costs, and in some instances, hurts access to certain types of health care.

If defensive medicine adds only 5 percent to our nation's health care bill, that's $50 billion that we can ill afford. That money should be spent on appropriate care for sick patients—not on inappropriate care of potential litigants.

Mr. Chairman, today's malpractice system is arbitrary. The reasons why physicians get sued are unclear. Studies have shown that physicians are usually not sued when malpractice occurs, and are often sued when they are not at fault. This helps explain why physicians feel vulnerable in the current system, and often believe they must perform procedures to protect themselves from future legal action.

There is still no evidence to show a correlation between a physician's malpractice claims experience and quality of care. In fact, a study published in the most recent issue of the *Annals of Internal Medicine* showed that the reasons why patients contacted a malpractice attorney were primarily: general dissatisfaction with the health care system; television advertising by law firms; and their financial circumstances. While medical liability laws may be addressing certain needs of patients, they are not, and must not be seen as, a guarantor of quality of care.

As you know, the current tort system provides little protection for patients. Studies have shown that many more patients suffer an injury from negligence than file a malpractice claim. An even smaller percentage receive compensation. Moreover, those who do recover often must wait several years as the litigation crawls through the legal system.

We need a liability system that provides appropriate compensation for patients who are injured, with much smaller transaction costs than we now incur. We need

a system that does not infect the physician-patient relationship with the looming threat that the two parties may end up in court. The reforms that we recommend are in the best interests of patients and physicians.

Medical malpractice reform will not solve all the problems in our nation's tort system. Nor will it necessarily end defensive medicine. However, it is a necessary first step that can help change the incentives in the system, thereby helping to restore the physician-patient relationship.

RECOMMENDATIONS

The ACP recommends a package of reforms based on the provisions of the California Medical Injury Compensation Reform Act (MICRA) including:

Cap on non-economic damages.—Caps on non-economic damages will ease physician fears of unlimited liability, and will reduce malpractice costs.

Elimination of joint and several liability.—This legal doctrine holds all defendants liable for the full award if any other defendants cannot pay their shares. It penalizes defendants who have to pay more than what would be warranted by their share of fault.

Offsets of awards from collateral sources.—Damage awards should be reduced by recoveries from other sources such as health insurance, disability insurance, and other sources.

Reasonable limits on statutes of limitations.—This will ensure that malpractice claims are reviewed in a timely way. Long statutes of limitations create uncertainty, delay, and expense.

Limiting attorney contingency fees.—Attorney contingency fees should be limited to less than 33⅓ percent based on a sliding scale to decrease the incentive to seek excessive damages. In the *Annals* article noted earlier, attorneys cited the low estimate of award as the most frequent reason for not pursuing a malpractice case. The patient is at the mercy of the lawyer's potential revenue estimate. This is compelling evidence of the need for sliding scale limits on contingency fees, in order to reduce the financial incentive for lawyers to pursue high awards and refuse cases that they do not see as financially promising.

These tort reforms have been successful. They have caused malpractice premiums in California to decline from 1976 to 1991.

The effectiveness of caps on non-economic damages in reducing costs was recently affirmed by the U.S. Office of Technology Assessment. In its latest report, the OTA concluded that "the one reform consistently shown to reduce malpractice cost indicators is caps on [non-economic] damages."

Although these reforms have successfully reduced some malpractice costs, there is no evidence that they have reduced defensive medicine, the number of frivolous suits filed, or the huge transaction costs associated with bringing a claim. Consequently, we urge adoption of other proposals:

Mandatory Binding Alternative Dispute Resolution.—Strengthening alternative dispute resolution methods is a key component of reform since they can reduce the time and expense of litigation for both sides. Thus, it should be mandatory for litigants to go through ADR before bringing a case into court. Some jurisdictions have used mediation and early neutral evaluation techniques with success. Others prefer a more traditional approach such as arbitration.

Regardless of the method, we believe ADR will lead to settlements of disputes and reduce the time and expenses of full-blown litigation. The key to making it work, however, is that the ADR must be binding on the parties or provide a strong disincentive so plaintiffs do not go to court after the ADR is completed. An example would be the "English Rule" which requires a plaintiff to pay the defendant's legal costs if he receives a lesser award at trial than that available from the ADR.

Pretrial screening.—We urge the adoption of a provision requiring that, before a case can proceed, a screening panel comprised of attorneys and physicians review a plaintiff's case and determine if there was a probability of negligence and that the negligence caused the injury.

A strong pretrial screening mechanism will help prevent spurious claims from entering the system. Each state could design its own panel, but they should consist of physicians and attorneys. The decision of the panel should be allowed as evidence in any subsequent trial.

No-fault demonstrations.—We recommend federal support for demonstrations of no-fault malpractice systems such as use of Accelerated Compensation Events (ACEs). The College has long argued that we need to move away from an adversar-

ial system to resolve malpractice claims, and toward a no-fault solution. Since proving fault is the basis of a lawsuit, if the plaintiff was not required to prove fault, it would save time and money for both sides. Of course, this type of system would also have to ensure that in return for a timely and definite compensation for injured patients, physicians would not be liable for non-economic damages.

Studies have shown that the use of ACEs and other methods to resolve disputes could be effective and save time. We believe it would be appropriate to fund demonstrations to determine the effectiveness of such programs.

IMPROVING QUALITY OF CARE

Mr. Chairman, most discussions of liability reform end up as shouting matches between doctors and lawyers. This prevents us from addressing the real issue—how to ensure that patients receive the highest quality care.

The malpractice system is ill-suited to perform this function. Its arbitrariness and lack of scientific foundation gives it no credibility with medical professionals. Its inability to provide timely and adequate compensation to injured persons creates cynicism and frustration for patients.

What we need is a new system to guarantee quality—a system that uses data to monitor physician practices and helps them improve their performance. Toward that end, the College supports a quality improvement system that uses data from practice profiles—of processes and outcomes—to measure quality. Use of this data in a system of ongoing quality improvement is the best way to ensure that patients get the best care.

Mr. Chairman, quality in medical care comes from professional imperatives to achieve excellence. It cannot be imposed externally, from government regulation or the tort system. The challenge is to design a system that fosters collaboration among physicians, hospitals, and health plans to improve quality, while simultaneously providing reasonable external review and consumer protection.

Physicians and health plans must take greater responsibility for the quality of the care they provide. When the data suggests a potential quality problem, it is the responsibility of the health plan and its practitioners to investigate the cause of the data variation and ultimately improve performance. If a particular physician is unwilling or unable to improve, the medical community must be willing to take appropriate action. Toward that end, state licensure boards must be given the necessary funding and authority to investigate and sanction physicians whose performance remains unsatisfactory.

Finally, Mr. Chairman, it should be noted that trends in the current health care system have exacerbated the need for liability reform. Specifically, insurance companies, through their "utilization review" procedures, have taken treatment decisions away from physicians. In addition, managed care organizations put pressure on physicians to more efficiently utilize resources, often by encouraging them to provide fewer services. Insurers can enforce these rules by terminating their contracts with physicians.

At the same time, however, patients expect that physicians will do whatever is necessary for them, regardless of the cost. Patients can use the tort system to back them up.

Thus, physicians are caught in a "Catch 22." They can be fired for providing too much treatment, and sued for providing too little.

This issue was dramatically illustrated recently by Dr. Christine Cassel, the Chairman of the ACP Health and Public Policy Committee, who testified before the Senate Finance Committee regarding care at the end of life. Dr. Cassel described how a physician's fear of being sued can create an adversarial environment that distorts the communication between the doctor and patient, just as they are making difficult but necessary treatment decisions.

In light of these considerations, we believe that tort reform becomes even more essential under the cross-pressures of managed care and other integrated systems. Beyond the reforms we have recommended, we urge further study of the concept of enterprise or organizational liability. While we recognize that past proposals in this area have their problems, it makes sense to us that, as we give health plans and networks the responsibility for providing care and for the quality of that care, we should also hold these organizations accountable for lapses in the quality of care. The concept deserves further exploration to determine whether it might be workable.

CONCLUSION

Mr. Chairman, we urge the Committee not to see the malpractice issue as a battle between physicians and patients. Most emphatically, the tort system does not pro-

vide adequate protection for patients who are injured during the course of medical care. Tort reform is at least as important for patients as it is for physicians. We hope that Congress and the advocacy groups who speak for consumers, as well as physicians, will view tort reform as a win-win issue for physicians, patients, and our health system as a whole, and come together on a significant package of reforms.

Thank you very much. I'll be happy to answer your questions.

AMERICAN COLLEGE OF PHYSICIANS,
PHILADELPHIA, PA,
May 20, 1994.

Hon. Robert Dole,
Senate Minority Leader,
S–230 Capitol Building,
Washington, DC.

DEAR SENATOR DOLE: Thank you for your interest in medical liability reform and the impact of defensive medicine on our nation's health care system. This letter is an attempt to answer your request from last week's hearing for specific examples of the costs of defensive medicine.

Treatment for a headache

A careful history and physical examination will provide a list of possible diagnoses. Usually, the most appropriate treatment is to identify the cause of the problem using non- invasive, simple studies, and employ appropriate therapy such as an analgesic or antibiotic. This treatment will cost about $50 to $100. For those patients who do not improve over a period of careful observation, more complex technology is appropriate.

Unfortunately, most patients demand that this complex technology be used immediately, and sometimes back up their demand with implicit or explicit threats of a lawsuit. A CT brain scan, including the radiologist's fee, will cost up to $800. An MRI will cost up to $1300.

Although patients fear that a brain malignancy or aneurysm will be missed, the former is uncommon, and the latter is very rare. In addition, if a brain tumor is eventually detected, the delay from use of low-intensity, non-invasive tests and observation is not harmful to the patient because it does not affect subsequent treatment.

Treatment for chest pain

An examination, case history, exercise stress test, and EKG is the appropriate treatment. This would cost about $200–$300.

Use of high-tech tests will cost significantly more money. For example, an isotope angiogram costs up to $2000, and a cardiac catherization costs about $3500. In addition, as I stated during the hearing, these extra tests do not provide definitive answers. These tests are often performed because physicians feel they must make their treatments "litigation-proof".

I hope these examples illustrate how defensive medicine increases health care costs. In each case, the additional expense for performing extra tests is not linked to improving quality of care, but rather to patient demands and a physician's liability.

Thank you for your interest in this important matter. Please let me know if I can provide you with additional information.

Sincerely,

CLIFTON R. CLEAVELAND, M.D., FACP,
President.

American Medical Association
Physicians dedicated to the health of America

James S. Todd, MD
Executive Vice President

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May 25, 1994

The Honorable Howell Heflin
Chairman
Courts and Administrative Practice Subcommittee
Committee on the Judiciary
United States Senate
223 Hart Senate Office Building
Washington, DC 20510

RE: Record Submission for the May 24, 1994 Hearing on Medical Liability Reform

Dear Chairman Heflin:

The American Medical Association (AMA) is pleased to submit these comments on the importance of incorporating federal medical liability reform as an integral part of health system reform. The Association has been proud to be at the forefront in assuming a strong leadership role in promoting reform of the nation's health care system.

However, meaningful health care reform will only be achieved by identifying and eliminating the inefficiencies that pervade the current civil justice system. Americans want our legal system to resolve medical liability claims in an equitable, timely, and effective manner. They want a system that fairly compensates all patients injured through medical negligence -- not one in which disproportionate economic awards inure to the benefit of a few claimants and their lawyers, while denying access to the courts to most others. Unfortunately, the civil justice system has acted as a major obstacle for both patients and physicians in achieving satisfaction with the present health care delivery system.

For these reasons, the AMA calls upon Congress to directly confront the critical challenge of overhauling the nation's medical liability litigation system within the broader context of the bold movement toward health care reform. We believe the enactment of comprehensive medical liability reform has great potential to further the central objectives of health system reform. It will help to increase access to medical and health care services, eliminate much of the need for defensive medical tests and procedures, ensure that health care professionals may use pharmaceuticals and medical devices proven to be beneficial in enhancing the quality of care, strengthen the physician/patient relationship, help prevent avoidable patient injury, and curb excessive and wasteful costs. A federal preemptive tort reform strategy will present a national solution to this longstanding problem, while preserving state prerogatives to implement additional or alternative reform programs that are equally effective.

More than twenty years of experience in a few states that managed to overcome legislative gridlock to enact meaningful liability reform offer valuable models to national leaders. The AMA believes the most effective path to medical liability reform lies in the enactment of uniform standards based on the 1975 California Medical Injury Reform Compensation Act (MICRA) The key components of this measure include: (1) limitations of $250,000 on the recovery of noneconomic damages; (2) mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing sliding scale regulation of attorney contingency fees; (4) periodic payment for future award of damages; and (5) reasonable statute of limitations reform.

The California innovations have been demonstrated to be effective over a 15-year period in containing costs, discouraging frivolous claims, promoting settlement of valid claims and expediting claims resolution. (SEE ATTACHMENT) Legislative action in other states, such as Indiana, Louisiana, and Nebraska, have yielded similar results. The most serious shortcoming in the Administration proposal lies in its omission of any monetary restriction on noneconomic damages -- the most decisive element necessary to the accomplishment of true reform in this essential area. In particular, a September 1993 Office of Technology Assessment (OTA) report, entitled *The Legal Impact of Reforms in the States*, identifies the ceiling on noneconomic damages as the single most effective tool in containment of health care liability costs. As the OTA report confirms, a ceiling on noneconomic damages represents the litmus test for the effectiveness of any reform package. We commend S. 1770, the "Health Equity and Access Reform Today Act of 1993," introduced by Senator John Chafee (R-RI), for incorporating this vital reform provision.

The Senate version of President Clinton's legislative proposal, S. 1757, the "Health Security Act of 1993," correctly recognizes that medical liability problems must be addressed. Yet it falls far short of offering a meaningful solution. A notable weakness of the "Health Security Act" is its failure to adequately restrict attorney contingency fees. The proposed 33 1/3 percent limit represents no reform at all, as it constitutes the typical share of awards now taken in the majority of liability cases handled on a contingency basis. S. 1757 also neglects to consider whether the one-third contingency applies to the plaintiff's gross recovery before litigation expenses, which often are charged against the claimant's remainder after the one-third contingency is already calculated. The RAND Corporation estimates that only 43 cents of every dollar spent in medical liability litigation reaches injured patients. While our system ostensibly is designed to compensate the injured, this appropriate goal is not being realized. The attorney fee limitation contained in the "Health Security Act," moreover, will not serve to mitigate this problem. In the end, this "reform" provision merely reaffirms the status quo.

The failure to impose a limitation on the period for suspending the application of state statutes of limitation, particularly with regard to minors, highlights yet another glaring deficiency in the "Health Security Act" of a reform provision that RAND and others have found to be particularly effective. In addition, the proposed demonstration projects to

explore the untested theory of enterprise liability would consume valuable resources that could be better utilized in studying the operation, effect of liability costs, and patient safety/injury prevention results of existing liability channeling systems.

S. 1757 attempts to respond to the flaws inherent in our medical liability litigation through inclusion of an alternative dispute resolution (ADR) mechanism. The ADR system envisioned in the bill denotes an attempt to preserve the right of access to a jury trial by making the procedure nonbinding. However, as the Michigan experience with voluntary ADR has demonstrated, only mandatory, binding ADR, in which an ADR decision is admissible as evidence in court, will offer a constructive alternative to litigation. If the jury is not informed that the dispute has already been exposed to some form of legal process ADR merely becomes an expensive litigation add-on. Finally, under federal preemptive tort reform, existing state ADR provisions and worthy demonstration projects, such as those occurring in Maine and other states, to evaluate the use of clinical practice guidelines can proceed.

In addition, the "Health Security Act" would direct public disclosure of "repeat offenders" reported to the National Practitioner Data Bank. Rather than pursuing appropriate quality management and patient safety programs, S. 1757 misguidedly contemplates that raw malpractice data in the data bank will provide useful information to patients in avoiding injury or assessing the competency, ethical practice, or the quality of care that their physicians provide. This expectation is completely unfounded. Instead, the AMA strongly urges that these provisions should be replaced by meaningful, effective patient safety reforms that would promote: (1) strengthening of state licensing boards and the peer review process to effectively identify and discipline incompetent and unethical physicians and health care providers; (2) bolstering confidentiality and immunity provisions to encourage witnesses to come forward; (3) expanding research to improve the ability to measure outcomes and accurately diagnose illnesses and injuries; (4) requiring health care delivery systems to implement coordinated patient safety programs in every hospital and clinic; (5) establishing programs to improve communication between patients, physicians, and other health care providers; and (6) expanding drug use review programs to identify patients who are overtreated or have developed adverse reactions to a combination of prescription drugs.

Finally, the Administration's proposal can be strengthened by focusing attention on the issue of injury prevention. Patient safety is critical to consumers, as well as to the vast majority of doctors who seek to avoid mistakes and protect their patients from injury wherever and whenever possible. The AMA believes that aggressive risk assessment and management strategies must be integrated as an explicit objective of quality management in every health service delivery setting.

The time for effective medical liability reform is now. As a member of the Health Care Liability Alliance (HCLA), the AMA has joined with a number of other organizations from the liability insurance, health insurance, medical products, and hospital sectors.

These groups have come together to advocate that any national health system reform legislation must incorporate, as a guiding principle, strong medical liability reform applicable to health care professionals and institutional providers, as well as to the producers of medical products.

It is clear that the spiraling costs of our dysfuntional liability system are borne by all of society. The cost of professional liability premiums, which has been a significant factor contributing to the growth in patients' medical and health care bills, as well as the fastest growing component of physicians' practice costs, has been placed at more than $9 billion in 1991 and continues to escalate. The California experience has shown that comprehensive liability reform has cut liability insurance premium costs by 60 percent over the 15-year period between 1976 and 1991. This reduction is crucial inasmuch as high premium costs and the threat of litigation have caused physicians all over this country to abandon their medical practices, leaving many communities, particularly in underserved rural and urban areas, without appropriate medical services.

Every recent poll has demonstrated that the American public strongly supports effective medical liability reform as a component of health system reform. By encompassing an innovative and comprehensive approach to addressing the complex problems of the current liability environment within the context of health system reform, such as medical liability reform based on the proven California model, the current initiative will achieve success in containing
costs, providing access to health care services, and promoting the quality and safety of medical care.

Sincerely,

James S. Todd, MD

Attachment

Percentage of GNP Going for Liability Costs

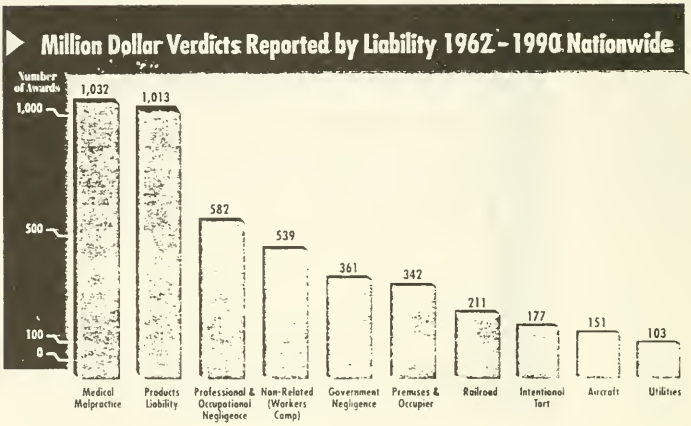
Liability costs in the United States are ***five times greater*** than liability costs in other countries, robbing America of needed capital and dulling its ability to compete in the international marketplace.

SOURCE: The Economist

Charts 1

Why the California Legislature Singled Out Medical Malpractice For Reform

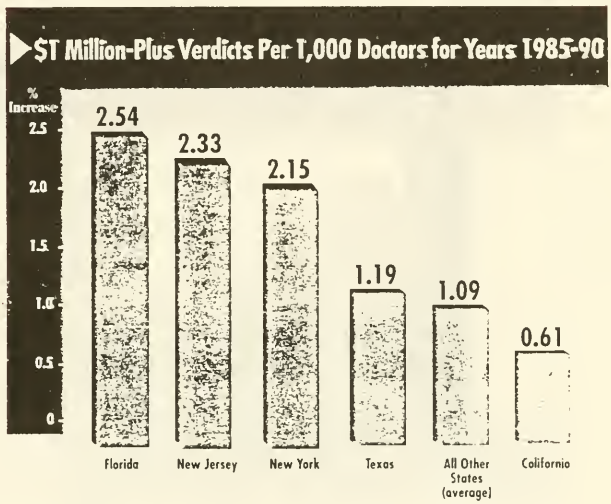
Medical malpractice was singled out by the California Legislature for special treatment in the law because **nationwide** there are more million-dollar-plus awards for this form of liability than for any other non-vehicular liability exposure



SOURCE [illegible] Charts 2

MICRA Works in California

Because of MICRA's $250,000 cap on awards for non-economic losses and its limits on attorney contingency fees, the number of million-dollar-plus malpractice awards is substantially lower in California than in states that have failed to enact MICRA-like reforms — lower even than the average of all other states.

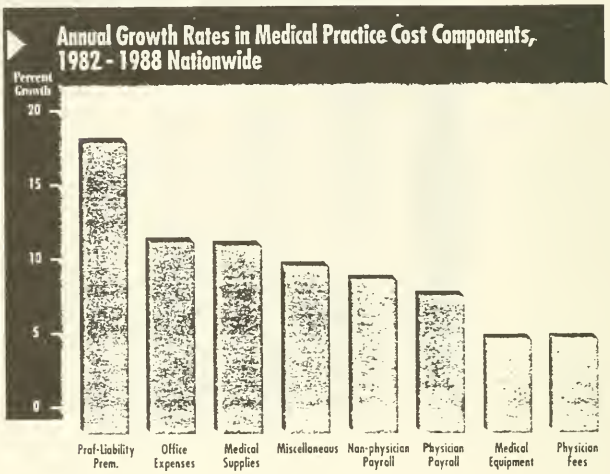


SOURCE: [illegible] Jury Verdict Research [illegible] Years 3

Annual Growth Rates

Annual Growth Rates in Medical Practice Cost Components 1982-1988

Nationwide, professional liability insurance is the fastest growing component of medical practice costs — but not in California.



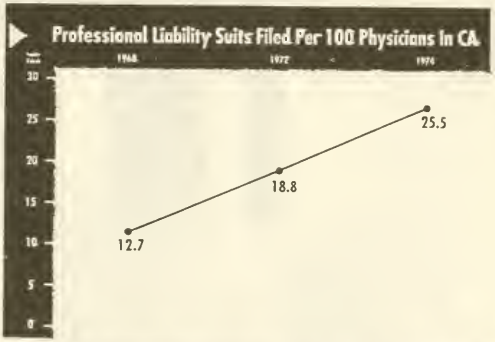
SOURCE: American Medical Association

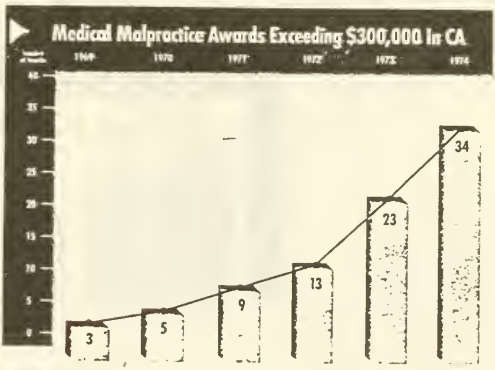
Before MICRA: Real Crisis

The cost of liability insurance is driven by two factors: the *frequency* of lawsuits filed against health care providers and the *amount awarded.*

As the first chart demonstrates, the number of malpractice lawsuits filed against California physicians more than doubled between 1968 and 1974, creating a crisis among liability insurance carriers.

Further fueling the crisis that resulted in MICRA's passage, the amount of awards skyrocketed at an equally alarming rate. As the second chart indicates, the number of malpractice awards over $300,000 increased tenfold between 1969 and 1974.



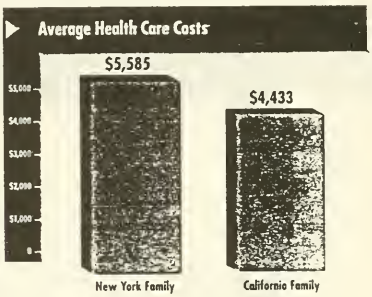


SOURCE: Joint Legislative Audit Committee Report

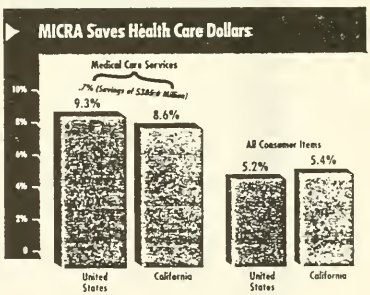
After MICRA: Real Results

MICRA Helps Control Medical Costs in California — Without MICRA, Medical Costs Would Be Even Higher

By controlling the cost of liability insurance, MICRA has slowed the increase of health care costs in California. As illustrated in the first chart, a recent consumer study by "Families USA" shows that health care costs for the average New York family in 1991 were $5,585 — compared to $4,433 for the average California family.



Further, as seen in the second chart, although consumer costs in California generally were higher than the national average in 1991, the state's medical care services index was lower. In 1991, California's medical costs increased less than medical costs for the nation as a whole, saving Californians $385.6 million.

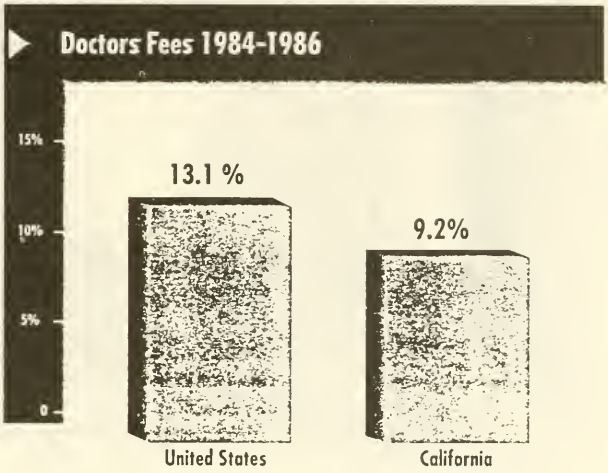


SOURCE: 1 Families USA
2 Source: Consumer Price Index for All Urban Consumers (CPI-U), 1989-1990, based on an average from the Los Angeles and San Francisco Bay Area indexes

MICRA Helps Keep Californians' Medical Bills in Check

Without MICRA, Doctors' Fees Would Be Higher

From 1984 to 1986, doctor fees nationwide increased 13.1% — but only 9.2% in California. If California doctor fees had increased at the national rate during this period, the added costs to California consumers would have been $790 million.



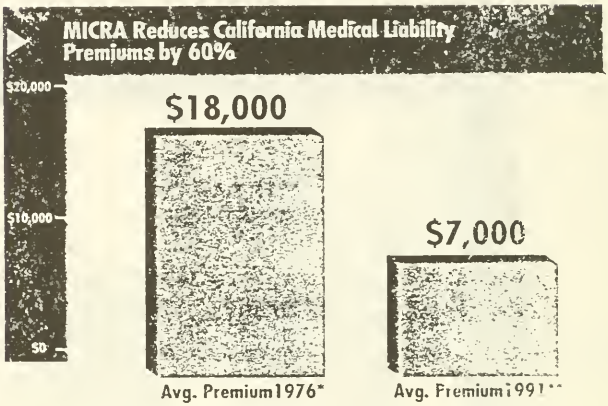
*Note: MICRA was upheld by the California Supreme Court in 1984-85

SOURCE: American Medical Association

Insurance Premiums Cut

MICRA Has Cut Medical Liability Insurance Premiums by 60%

Before MICRA took full effect, California physicians paid an average $18,000 for liability insurance in 1976. By 1991, MICRA had reduced the average liability premium to $7,000 — a 60% savings.



— Shown in 1991 dollars

* $7,241 average premium adjusted to 1991 dollars on the December Urban CPI Index

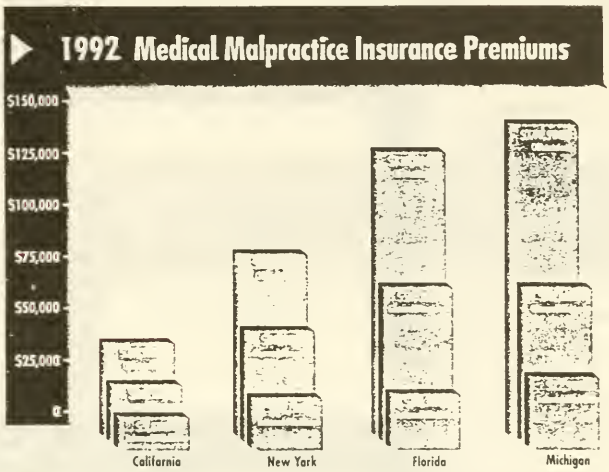
** Dividends from 1990 deducted from 1991 average premium.

SOURCE: [illegible] 3

California Premiums Are Now Lower

Thanks to MICRA, liability insurance rates for California physicians are now one-third to one-half those paid by physicians in states that have failed to enact MICRA-like reforms and that benefits all Californians

Based on average published rates excluding discounts or surcharges for *one to three million dollars in liability coverage.*

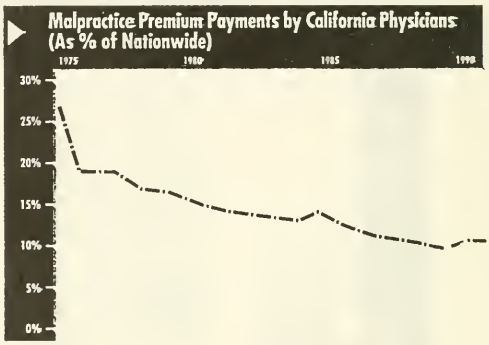


SOURCE: Medical Liability Monitor

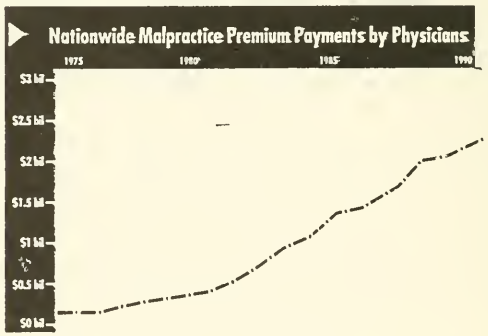
Malpractice Premium Payments for Physicians, California and Nationwide 1975 - 1990

Although medical malpractice premium payments for physicians nationwide have continued increasing since 1975, those costs for California physicians decreased over that same period. The only definite factor which can account for the difference is MICRA.

MICRA has reduced malpractice premium costs for California physicians...



... while nationwide malpractice premium costs for physicians have soared.

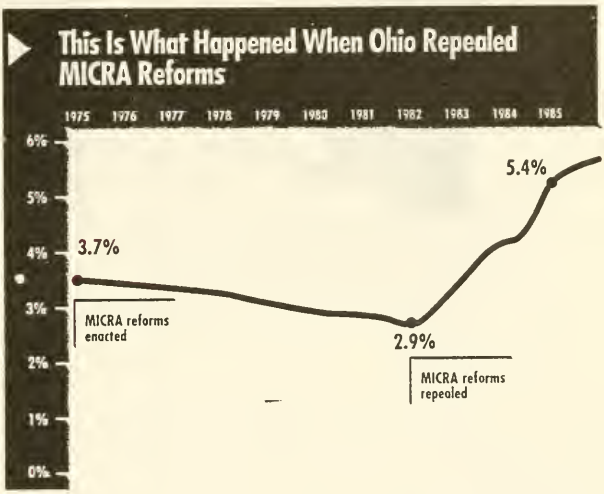


SOURCE: Tillinghast

Effect of the $250,000 CAP on Non-Economic Damages

Ohio Professional Liability Payments as a Percent of Payments Nationwide

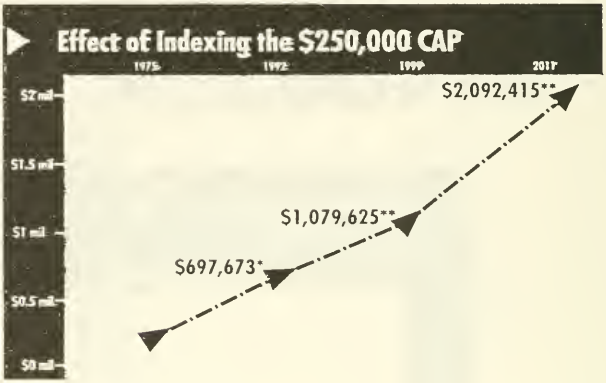
Ohio adopted MICRA reforms in 1975, when payment of medical malpractice claims in the state of Ohio was 3.7% of the total paid out nationwide. That percentage declined to 2.9% from 1975 to 1982 while the reforms were in force. In 1982, the Ohio Supreme Court invalidated the $250,000 cap on pain and suffering, and by 1985 Ohio's percentage of nationwide claims had climbed to 5.4%



SOURCE: Tillinghast

Effect of Indexing the $250,000 CAP

Index the $250,000 cap back to 1975, and it would raise the cap to $700,000 today. Based on average increases in the CPI over the past 16 years, the cap would then double every ten years, sending the cap spiralling out of control, eliminating its effectiveness in stabilizing liability and health care costs.



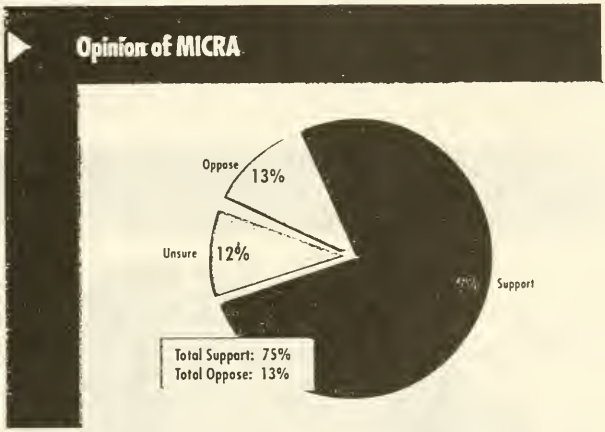
* based on actual changes in CPI

** based on average of actual CPI 1975-1992 of 5.61%

SOURCE

California Voters Support MICRA

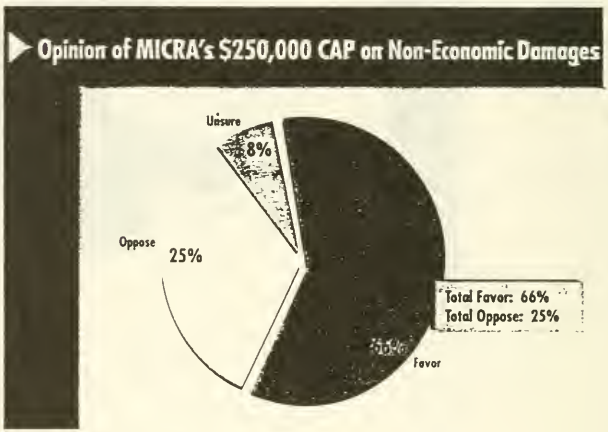
An April 1992 survey of registered voters in California revealed that 75 percent of Californians support MICRA.



SOURCE

California Voters Support MICRA's CAP on Non-Economic Damages

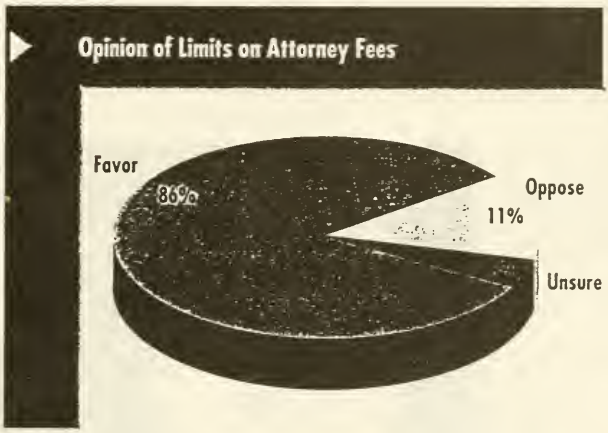
A survey conducted by the Tarrance Group in April 1992 showed that 66 percent of the registered voters polled in California favor the $250,000 CAP on non-economic damages provided by MICRA. It is important to remember that MICRA allows patients to recover 100 percent of their economic losses resulting from medical malpractice — including past, present, and future medical bills, lost wages, and other out-of-pocket expenses.



SOURCE: The Tarrance Group

California Voters Support Attorney Fee Limits

This chart dramatically illustrates just how positively the Californians polled in a recent survey feel about the limits on contingency fees paid to plaintiff attorneys provided by MICRA. By limiting attorney fees, MICRA guarantees that plaintiffs receive a greater share of their settlement award. Without MICRA's limit on attorney fees, California would return to the days when attorneys routinely took 40 to 50 percent or more of a plaintiff's award money.



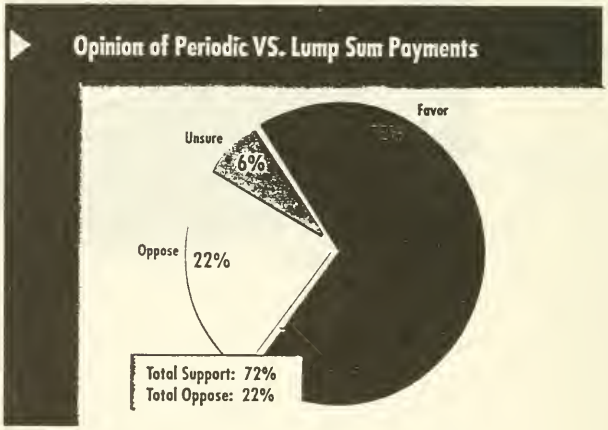
SOURCE: The Torrance Group

California Voters Support Periodic Payments

As shown in the chart, a recent survey of California voters revealed that 72 percent of those polled favor MICRA's provision to allow defendants to pay large awards for future economic losses in installments rather than as a lump sum.

Studies show that plaintiffs who receive large "lump sum" settlements often spend them quickly, without consideration for future medical and economic needs. Allowing payments to be made over time eliminates this problem. Periodic payments also can increase the actual "net" amount received by the plaintiff, because the investment proceeds from lump sum payments generally are considered *taxable income* — periodic payments are not.

Periodic payments help to provide long-term financial security to the injured patients who need it the most.



SOURCE: The Torrance Group

PREPARED STATEMENT OF CHARLES H. WALLAS, M.D., PRESIDENT ON BEHALF OF THE AMERICAN ASSOCIATION OF BLOOD BANKS

The American Association of Blood Banks (AABB) urges the enactment of comprehensive, nationwide medical liability reform. The AABB supports caps on non-economic damages, periodic payment of future damages, limits on contingent attorney fees, and consideration of collateral sources when awarding damages. We also support a uniform statute of limitations for medical malpractice lawsuits and a legal defense for working within medical practice guidelines.

We are pleased that much of the proposed health care reform legislation includes many of these important reforms. However, we are concerned that as currently drafted, the medical malpractice sections of some of these proposals may not cover actions brought against blood centers. Whatever form of medical liability reform is chosen, the AABB urges Congress to adopt legislation applicable to legal actions involving the providers of blood services.

The American Association of Blood Banks (AABB) is the professional medical society for approximately 2,400 community, regional and Red Cross blood centers, hospital-based blood banks and transfusion services and more than 9,000 individuals engaged in blood banking and transfusion medicine. Our member facilities are responsible for collecting virtually all of the nation's blood supply and for transfusing more than 80 percent of the blood used for patient care in the United States. Throughout its 47 year history, the AABB has been dedicated to maintaining a safe and adequate blood supply for the American people.

ALL BLOOD SERVICES PROVIDERS SHOULD BE INCLUDED IN MEDICAL LIABILITY REFORM

The AABB is concerned that as currently drafted, the medical liability reform sections of health care reform legislation may not apply to the liability challenges facing the blood banking community. AABB urges Congress to amend the definitions in the medical liability provisions of the legislation so that medical malpractice claims against blood service providers would clearly be covered.

We have found the following problem in Section 5301(a)(1) of the Health Security Act:

> The Act's liability reforms would apply to all MEDICAL MALPRACTICE CLAIMS;
>
> Medical Malpractice Claims are defined (in part) as claims against "* * * A HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL * * *"
>
> Health care providers and health care professionals are defined (in part) as "REQUIRED BY THE LAWS OR REGULATIONS OF THE STATE TO BE LICENSED OR CERTIFIED BY THE STATE."

The U.S. Food and Drug Administration (FDA) thoroughly and extensively regulates the collection, processing and distribution of blood and blood components. While some states have their own regulatory and licensing programs for blood services, most states defer to the FDA and do not provide for state licensure or certification of blood banks. Under the Health Security Act language blood establishments located in states without licensure or certification programs for blood establishments would be excluded from the definition of "health care provider" and, therefore, from inclusion in the bill's medical liability reforms.

As portrayed in the enclosed draft revision, we recommend modifying the definition of health care providers/health care professionals to include those "required by State OR FEDERAL laws or regulations to be REGISTERED, licensed, or certified to engage in the delivery of such services." This would cover blood centers in states without state licensure. Without our proposed amendment many blood centers might inadvertently be excluded from the federal medical liability reforms proposed.

We also recommend that health care reform legislation include a definition of the term "health care services." Since the states now each have their own unique definitions of this term, this action would further ensure uniformity in the treatment of health care providers and professionals.

To clarity that the medical malpractice provisions of the Health Security Act are applicable to legal actions against blood services providers, we recommend amendment of the bill's definitions so that blood services are clearly covered. We are including with our testimony our proposed definitions that would conform to President Clinton's Health Security Act.

BLOOD SERVICES ARE PERFORMED BY MEDICAL PROFESSIONALS

Including blood services in medical liability reform proposals would not only reduce litigation costs, it is good public policy. Blood services are performed by highly skilled and specialized medical professionals, including physicians, nurses, and allied health professionals. Hospitals and transfusion recipients rely on the medical skill and expertise of blood service providers in collecting, testing and processing blood.

The nature of blood services, the high professional standards to which blood services providers are held, and the necessity of safeguarding the safety and adequacy of the nation's blood supply all require that blood service providers be treated in the same manner as all other health care professionals. Including volunteer blood centers in whatever health reform passes this year will give life to the underlying intent of health care reform: to ensure the availability of all health care services—including blood transfusion—to every citizen.

BLOOD AND LIABILITY

Including blood services providers in medical liability reforms is consistent with state law. By virtue of the state "blood shield statutes" product liability actions against blood services providers are not allowed, and plaintiffs must establish negligence in order to recover court awards against blood services providers. However, since state legislators often do not specifically address whether blood services providers are entitled to the protection of state-enacted medical liability reforms, this issue must be litigated on a state-by-state basis. Resolution may involve complex legal arguments and result in lengthy appeals.

For example, after years of litigation, the California Supreme Court concluded that the collection, processing, and distribution of blood are professional medical services and that blood centers performing these services meet the California Medical Injury Compensation Reform Act's (MICRA) definition of health care provider. The Court decided that because blood banks provide a service that is inextricably identified with human health, they are health dispensaries entitled to the liability protections provided by MICRA.

These are just some of the issues appearing in litigation arising from the period prior to 1985 when there was no laboratory test to screen blood for Human Immunodeficiency Virus (HIV), the virus that causes AIDS. While almost all of these lawsuits are dismissed pre-trial or won in court, the litigation costs required to obtain these rulings are enormous. The AABB believes that these funds would be more appropriately devoted to patient care. We therefore urge Congress to craft Federal medical liability reform legislation so that it is clearly applicable to lawsuits against blood services providers.

HEALTH SECURITY ACT DRAFT REVISED DEFINITIONS FOR SECTION 5301 (B)

(3) HEALTH CARE SERVICES.—The term "health care services" means any service provided by a health care services professional or health care services provider, or by any individual working under the supervision of a health care services professional, that relates to the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

(4) HEALTH CARE SERVICES PROFESSIONAL.—The term "health care services professional" means any individual who provides health care services in a State and who is required by State or Federal laws or regulations to have adequate educational background, training and experience, including professional training as necessary, to assure competent performance, or to be registered, licensed, or certified to provide such services; or who is certified to provide health care services pursuant to a program of education, training, and examination by an accredited institution, professional board, or professional organization.

(5) HEALTH CARE SERVICES PROVIDER.—The term "health care services provider" means any organization or institution that is engaged in the delivery of health care services in a State and that is required by State or Federal laws or regulations to be registered, licensed, or certified to engage in the delivery of such services.

[renumber (5), (6), (7); throughout subtitle substitute "health care services professional" for "health care professional" and "health care services provider" for "health care provider"]

* This amendment is supported by:
The American Association of Blood Banks (AABB)
The American Association of Tissue Banks (AATB)
The American Red Cross (ARC)
The Council of Community Blood Centers (CCBC)

Questions and Answers

U.S. Department of Justice,
Office of Legislative Affairs,
Washington, DC, August 9, 1994.

Hon. Howell Heflin,
Chairman, Subcommittee on Courts and Administrative Practices,
Committee on the Judiciary,
U.S. Senate,
Washington, DC.

Dear Mr. Chairman: Thank you for providing us with an opportunity to present the Administration's views on medical malpractice issues in health care reform. Pursuant to your request, enclosed are responses to the written questions submitted following the May 24, 1994, hearing before the Subcommittee on Courts and Administrative practice. I apologize for the delay in our response.

If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

Sheila F. Anthony,
Assistant Attorney General.

Answers to Questions From Senator Thurmond to Sheila F. Anthony, Assistant Attorney General

Question 1. On the issue of limiting attorneys' fees, how was the limit of one-third chosen for the Health Security Act? Was there consideration of a sliding scale that depends on how far the case has progressed and reduces the percentage of attorneys' fees as the award increases?

Answer 1. Medical malpractice litigation can be costly litigation, involving protracted discovery, use of expert testimony, use of costly graphics or other visual representations at trial, and extensive attorney time spent in trial and trial preparation. In some jurisdictions, the definition of attorneys' fees includes such litigation expenses, as well as billable attorney time. Many states have adopted medical malpractice reforms relating to attorneys' fees and expenses, including caps on fees at various levels. The limitation on attorneys' fees set forth in § 5304 of the Health Security Act is consistent with the most common of those reforms. The provision is intended to assure access to justice for all claimants, including those of modest means, while preventing attorneys from recovering undeserved or excessive fees.

Question 2. Would it be permissible for medical providers and patients prior to treatment to enter into agreements to use binding arbitration procedures for any malpractice claims which may result from the treatment?

Answer 2. Binding arbitration agreements to resolve health care disputes, including medical malpractice claims, have been used by various health plans and health care providers. Such contracts have generally been upheld by state courts. See, *Madden* v. *Kaiser Foundation Hospitals,* 552 P.2d 1178 (1981). Only two states, Nebraska and South Carolina, specifically prohibit pre-treatment arbitration contracts. The Health Security Act would not affect such agreements.

Question 3. My final question is about the provision in the Health Security Act to make information about the existence of malpractice sanctions and payments available to the public. What is your response to concerns that this may cause medical providers to refuse to settle cases and to avoid risky specialties and high-risk patients?

Answer 3. The Health Security Act would, for the first time, make available to consumers information from the National Practitioners Data Bank regarding repeated numbers of malpractice payouts, including settlements and disciplinary sanctions. Broad public access to such information is essential to health care reform and the provision of quality health care to all Americans. Making such information available to the public should have no impact on the litigation of malpractice cases or on the provision of health care services by competent practitioners.

ANSWERS TO QUESTIONS FROM SENATOR GRASSLEY TO SHEILA F. ANTHONY, ASSISTANT ATTORNEY GENERAL

Question 1. What consideration did the Clinton Health Care Reform Task Force give to limitations on punitive damages, directing punitive damages be paid to governmental or private organizations dedicated to improving the quality of medical care, and modifications in joint and several liability?

Answer 1. Punitive damages are rarely awarded in medical malpractice cases litigated under state law. In most states, punitive damages are awarded for "gross negligence", "wanton" or "willful" conduct, or some similar standard. That degree of culpability is rarely applicable in malpractice actions. As a consequence, punitive damage reform was not considered to be a meaningful approach to reducing the incidence of defensive medicine and the costs and delays of malpractice litigation.

Joint and several liability is a fundamental concept of tort law. A few states have attempted reform in this area, usually in the context of more generalized tort reform. The Health Security Act seeks to respect the fundamental nature of state tort law and procedure. In the Administration's view, modifications in the doctrine of joint and several liability would not reduce the costs or delays of malpractice litigation and would be an inappropriate intrusion into this fundamental area of state common law.

Question 2. Who were the members of the Clinton Health Care Reform Task Force who drafted the provisions of the Clinton Health Security Act regarding medical malpractice?

Answer 2. Attached is a list of the participants in the interdepartmental working group which studied medical malpractice issues.

Question 3. What is the Administration's view of the amendment adopted by the Senate Labor Committee in its recent mark-up limiting attorneys' contingent fees to 25 percent of the award?

Answer 3. The amendment adopted by the Senate Labor Committee would limit attorneys' contingent fees to 33⅓ percent of the first $150,000 of the total amount recovered by judgment or settlement, plus 25 percent of any amount recovered above $150,000. The Administration has no objection to that amendment.

Question 4. What is the rationale for including only health care "providers" in malpractice reform and excluding the manufacturers of medical device and drug companies? In other words, why have different legal standards and procedures for different defendants in cases which arise out of the same facts and circumstances?

Answer 4. The manufacturers of medical devices and drugs are not usually the targets of medical malpractice suits. While claims of negligent manufacture or design of such products or strict liability in tort could be joined with malpractice claims against doctors, hospitals, or other health care providers, the infrequency of such claims does not warrant including the wholesale reform of medical product liability law in an effort to reduce the costs and delays of medical malpractice litigation. Medical product liability has been and will more appropriately be debated in the context of product liability reform.

HEALTH CARE WORKING GROUPS

MALPRACTICE AND TORT REFORM

NAME	ORGANIZATION
AUKERMAN, GLEN	HHS-HEALTH RESOURCES & SERVICES ADMINISTRATION (HRSA)
BAUM, NANCY	HHS-HCFA
BERENSON, ROBERT	HHS-PRACTICING INTERNIST
DONESKI, ELLEN	SENATOR JAY ROCKEFELLER
EDDY, JUDITH	HHS-RESEARCH ASSOCIATE-DUKE UNIVERSTIY
EULER, JOHN	JUSTICE
GOVAN, REGINALD	HOUSE COMMITTEE ON EDUCATION AND LABOR
HADLEY, ELIZABETH	HHS-ASPE
HASTINGS, KATHLEEN	HHS-PHS-AHCPR
HUCKABY, MICHELLE	REPRESENTATIVE BOB CLEMENT
MEADOW, CYNTHIA	REPRESENTATIVE JACK BROOKS-HOUSE JUDICIARY COMMITTEE
RADACK, LAURA	JUSTICE
REEVES, LINDA	HHS-AHCPR
SCHULTZ, WILLIAM	REP. HENRY A. WAXMAN-HOUSE CMTE ENERGY/COMMERCE
STACHELBERG, CYNTHIA	OMB
TAPLIN, CAROLINE	HHS-PHS
VARNHAGEN, MICHELE	SENATOR HOWARD METZENBAUM
WEICH, RONALD	SENATE LABOR AND HUMAN RESOURCES COMMITTEE

ANSWERS TO QUESTIONS FROM SENATOR THURMOND TO PAUL B. GINSBURG

Question 4. Could each of you on the panel please give your views on whether you think physicians and other providers will be less careful or act less competently if medical malpractice procedures are reformed? For example, if the expense resulting from a malpractice incident were to decrease from $500,000 to $100,000, would you expect medical providers to be less careful?

Answer 4. If malpractice awards were reduced, I would not expect a direct effect on the care with which individual medical providers practice medicine. The cost of paying specific malpractice awards is not borne directly by providers, but by their malpractice insurers. The effect of the malpractice system in deterring negligence most likely stems from physicians' desires not to be sued in the first place and not to be found guilty of negligence if sued. The precise size of the award is probably of much lesser importance. In other words, the deterrence effect of the malpractice system on individual providers is so strong that it would not be significantly weakened by some reduction in award levels.

In theory, there may be an indirect effect on organized systems of care that self-insure and actively attempt to prevent medical injuries. For such organizations, the cost of preventing a particular type of injury must be weighed against the cost of the injury itself. If the cost of the injury (as measured by the malpractice award) is decreased, then the organization's incentive to prevent it would be reduced. However, incentives to prevent injuries would be better strengthened by including more negligent injuries within the malpractice system than by maintaining high levels of payment for those relatively few injuries that now result in compensation.

Question 8. Could each of you please state your views on whether it would be permissible for medical providers and patients prior to treatment to enter into agreements to use binding arbitration procedures for any malpractice claims that may result from the treatment?

Answer 8. I am not an expert on the constitutionality of such agreements, but such contracts ought to be valid when executed in advance of the need for treatment (so as to avoid the appearance of coercion or undue pressure). This is easier to do for organized systems of care than for individual physicians. I do not recommend, however, that all claims be required to be resolved through arbitration at this time. More needs to be learned about how medical malpractice arbitration programs should be constructed to be efficient and fair. Ideally, the advantages of arbitration to both patients and providers should be sufficiently clear that they would voluntarily enter into binding arbitration agreements.

Question 9. On several issues, some of you indicated in your written testimony that no action should be taken by the Congress until more experience is developed by the States. To what extent do each of you think that medical malpractice or parts of the malpractice system should continue to be resolved under State law, as it has been traditionally?

Answer 9. The performance of today's malpractice system compromises important federal interests in the cost, quality, and accessibility of health care. Piecemeal or limited reforms are unlikely to have a major impact. When the evidence is compelling that particular reforms are needed, the Physician Payment Review Commission has recommended federal legislation described in my written statement. For other reforms, the Commission has recommended that the federal government fund or evaluate state demonstrations. These include certificate of merit programs, according special legal status to practice guidelines in malpractice litigation, and demonstrations of enterprise liability and alternative standards for compensation such as no-fault.

ANSWERS TO QUESTIONS FROM THE SUBCOMMITTEE ON COURTS AND ADMINISTRATIVE PRACTICE TO JOHN H. NILES, M.D.

Question 1. Could each of you on the panel please give your views on whether you think physicians and other providers will be less careful or act less competently if medical malpractice procedures are reformed? For example, if the expense resulting from a malpractice incident were to decrease from $500,000 to $100,000 would you expect medical providers to be less careful?

Answer 1. Placing a cap on the amount a jury can award for non-economic damages in a medical malpractice lawsuit will not decrease the quality of medical care physicians currently provide. At the outset, it is important to put this question in context: According to the Harvard Study, health care is completely safe for 99 percent of hospital patients. Therefore, any health care liability system should be designed to target providers who engage in the one percent of cases that may involve unsafe or unethical practices.

In cases where adverse events do occur, no one disputes that people injured in the course of receiving health care treatment are entitled to fair and prompt compensation, but the truth is that the current tort system does not satisfy these objectives. That is why the Health Care Liability Alliance believes that reform of the medical liability system must include safeguards against medical malpractice. The health care community is committed to continuing efforts to reduce the incidence of injury and strongly supports reform efforts to promote patient safety and identify incompetent providers or unethical practices.

Caps on non-economic damages will not adversely affect physician behavior. The tort system will still be in place to resolve adverse events. From the doctor's perspective, there are no logical motives for practicing medicine in a negligent fashion. Roughly two-thirds of all medical malpractice cases are dropped without any payment at all, yet the physician still must endure the stress, time and expense of defending himself or herself—making a cap on non-economic payments irrelevant to the physicians themselves. Under the Health Care Quality improvement Act, *any payment* made in response to a medical malpractice case must be reported to the National Practitioner Data Bank. Finally, and even most importantly, the physicians that I know take their Hippocratic Oath *"to do no harm"* very seriously and are in this profession to help people.

By contrast, limiting the size of the jury award promotes predictability and stability of the medical liability portion of health care costs. Savings in this area can be passed on to the ultimate beneficiaries—consumers.

Question 2. Do you think that the $250,000 cap you propose on non-economic damages should be indexed to inflation so that the real recovery permitted would not be diminished over time?

Answer 2. The Health Care Liability Alliance (HCLA) which I am representing at this hearing, opposes indexing non-economic damage caps to inflation. Please let me be clear that I believe that injured patients are entitled to the recovery of measurable economic damages like medical expenses, lost wages and future income and extraordinary living expenses. All of these economic damages can already be recovered by injured patients in inflation-adjusted dollars. But no jury or judge, no matter how well meaning, will be able to determine an amount of money that would fairly compensate an injured patients for pain and suffering caused by medical malpractice. Compassionate people would like to make the injured person whole again—but no amount of money, not $900,000, not $1 million or perhaps even $2 million, will turn back time.

It should be noted that by international comparison, a $250,000 limit on non-economic damages is very high. As far as I know, no other country provides larger compensation for this impalpable element of damages. The variation between countries underscores the fact that pain and suffering awards are arbitrary by definition. Individuals from the same city suffering similar injuries are not compensated consistently, let alone individuals from different states or countries. So the notion that fairness demands of adding an *economic* index to pain and suffering awards has no economic basis. Limiting non-economic damages has been proven to be the most effective reform at containing liability costs. Indexing the limit would result in the expenditure of more health care dollars to perpetuate the inequities inherent in our tort system—where everyone pays for disparate awards which collectively help the trial bar more than injured patients because of the contingency fee system.

Moreover, the *unpredictability* of jury awards for non-economic damages in medical liability cases makes insuring physicians, hospitals and other health care providers very difficult, risky and expensive. Because an individual's medical expenses and lost wages can be estimated by examining past payment data and socio-economic data in the area where the policy is issued, it is possible for insurers to project how much future liability claims might cost so that adequate funds to pay injured patients and their families will be readily available. Contrarily, there is no database which courts could use to measure the value of a patient's health and well-being. There are no natural parameters for estimating the potential expense of medical malpractice cases. A cap on non-economic damages creates such a parameter. If a fair, stable cap on non-economic damages is enacted at the federal level, insurance companies nationwide can better predict their risks, fostering competition, reducing premiums to make insurance affordable for all physicians as has been the case in California. The net effect is that very few claimants will be truly disadvantaged, lawyers will take fewer health care dollars out of the system, and the malpractice premium portion of health care costs will go down.

Question 3. Could you please state your views on whether it would be permissible for medical providers and patients prior to treatment to enter into agreements to use binding arbitration procedures for any malpractice claims that may result from the treatment?

Answer 3. Yes. I believe health care providers and patients should have the option of entering into agreements or contracts for binding arbitration procedures. It should be noted that both plaintiffs and defendants waive their right to a trial in such circumstance, but so long as the process is fair, I see nothing wrong with giving parties the right to forgo litigation. Certain health plans currently have the option of arbitration (as well as other alternative dispute resolution [ADR] procedures) which can be beneficial to patients and to providers in several ways. Binding arbitration can often close medical malpractice claims in more timely fashion than litigation, which takes an average of five years from the time a malpractice incident occurs until the claim is closed. The timely resolution of malpractice cases is in the best interest of the patient, because patients with legitimate claims will be compensated more quickly. Binding arbitration is also more cost effective for all the parties involved because the longer it takes to resolve cases that are sent to court, the more the attorney's fees, court costs and other administrative expenses accumulate. Finally, from a humane perspective, the longer the case is prolonged in our sluggish civil justice system, the greater the stress on the individual health care provider(s) involved, the patient involved and their families.

We are already seeing health care reform being driven by the private sector. Many areas are already embracing the principles of managed care and establishing networks of hospitals, doctors and other health care facilities in order to increase the efficiency and reduce costs. Contractual binding arbitration and other forms of ADR are increasingly being utilized in these new networks as a way to mitigate liability related costs, including the direct costs of liability insurance premiums for the providers and the facilities and indirect costs such as increased testing due to the practice of defensive medicine. As more and more of our health care system undergoes positive reform, contractual arbitration and other types of ADR may present an excellent option to the present tort system, which is costly, unfair and inefficient. Contractual ADR could be fine-tuned to ensure that it is fair much more easily than our current system which is governed by State laws which are difficult to improve because the State Trial Bars have the political clout to block any changes proposed in our State Legislatures. In conclusion, I believe that contractual arbitration and other binding ADR options should be one of the choices that all Americans have in choosing the health plan that is best for them and their families, as long as we ensure that all such binding arbitration procedures are fair and balanced for *both* patients and providers.

Question 4. On several issues, some of you indicated in your written testimony that no action should be taken by the Congress until more experience is developed by the States. To what extent do each of you think that medical malpractice or parts of the malpractice system should continue to be resolved under State law, as it has been traditionally?

Answer 4. It is clear that given the pace of private sector-driven health care reform, and the emergence of interstate health care networks hospitals and providers, *the enactment of minimum federal health care liability standards is needed.* Federal leadership is necessary because the current health care liability system is expensive and unfair to all Americans, as well as defendants and plaintiffs. States should be provided with maximum flexibility to tailor these mandatory reforms to conform to the rapidly changing health care systems in the States.

- The current health care liability system is *unfair to all Americans* because meritless medical malpractice suits increase every American's health care costs. For example, an April 1994 Hudson Institute study estimated that in Indiana, legal liability added an average $450 to each patient's hospital bill, $327 to each patient's doctor bill and $123 to each individual's health care insurance premiums.
- The *defendants or health care providers suffer under the current health care system* too, because 40 percent of all physicians can expect to be sued in their careers, yet two-thirds of these suits are dropped without any payments.
- The *system is unfair to plaintiffs* because the contingency-fee system gives attorneys no incentives to take smaller cases. If a plaintiff has a larger case, that is, a case which might result in large cash award, the injured patient usually receives only 40–50 cents of every medical malpractice insurance dollar, while the contingency fee system allows the lawyer(s) to keep the balance

With or without federal health care reform legislation, the private sector will continue the current trend toward the establishment of large integrated health care networks which cross State lines, making national standards more practical than the current patchwork system of State laws. In some States or jurisdictions, like the District of Columbia, where I practice, there has not been any progress or innova-

tion in the area of tort reform because the D.C. City Council is dominated by individuals with close ties to the Trial Bar, virtually *the only entity which benefits from the current health care liability system.* So, federal standards would provide welcome relief to physicians like me, who currently practice in the District, as well as, health care networks which are interested in expanding their organizations here.

I agree with your premise, Senator Thurmond, that the States have provided us with a lot of valuable data on the types of tort reforms which work. California's Medical Injury Compensation and Reform Act and Colorado's Health Care Availability Act both incorporate caps on damages, limits on attorney's contingency fees and periodic payment of awards. In both States, health care liability costs have been contained, while health care liability costs have increased at a rate which outpaces inflation in other States and the District which have not enacted any real tort reform laws. In California, which has adapted a $250,000 cap on non-economic damages, and in the twenty-one other states that have enacted a limit on non-economic or economic damages, these reforms have been working for nearly twenty years, so we should not hesitate to implement similar limitations at the federal level.

In summary, I would support the enactment of a comprehensive federal tort reform law, which would require the States and the District to meet minimum standards, but would preserve their ability to experiment with stronger, more innovative laws. Additionally, I believe it is important to allow the States to continue to develop better patient safety, risk management and medical credentialing and disciplinary measures. All these programs are intended to *prevent medical injuries,* which is much more cost-effective than medical malpractice suits. Many States have developed excellent programs in these areas, but there is room for vast improvement and a desperate need for additional funding so that State agencies perform these functions efficiently. Federal intervention to provide the States with incentives to implement innovative patient safety and risk management activities and to assist in disseminating information about successful patient safety and risk management programs could help save patients and health care providers from the anguish of becoming entangled in a law suit.

Let me close by emphasizing that last point. One aspect of our current health care liability system that is currently overlooked is the great personal price that I and many of my colleagues here in the District of Columbia and across the nation face when we are served with papers informing us that a malpractice case is being filed against us. With few exceptions, in the cases where a handful of very bad doctors have willfully neglected or harmed their patients, the doctors being sued were doing their professional best to care for patients. *I strongly support all initiatives to ensure that such willfully negligent doctors be appropriately punished under all relevant laws and medical standards.* But many medical liability cases are due to the fact that doctors are human and medicine is an imperfect science, things go wrong and patients are not provided with the optimal results. Our health care liability insurance is intended to provide compensation to impacted patients and their families in these circumstances, but there are many unintended effects of our entire liability system. For example, in my own area of practice—obstetrics and gynecology—7 or 8 out of every 10 of my colleagues can expect to be sued during their career regardless of the quality of care they provide. Yet, roughly two-thirds of all medical malpractice claims are closed because they lack merit. The emergence of the "lottery mentality" practice of personal injury law—where plaintiff's attorneys initiate a large number of malpractice suits in the hope that a handful will hit the "jackpot" with large awards is such an unintended consequence. Regardless of whether these numerous suits are ultimately dropped, these suits require that a physician take significant time away from his or her practice to prepare to defend himself or herself against the malpractice charges. The emotional anguish that my colleagues, their fellow providers and their families often endure because of frivolous law suits is a facet of our current liability system that is lost in the debate over tort reform. Many physicians worry about how these suits impact their professional reputation, and if their practice will suffer as a result. My specialty requires that physicians be available twenty-four hours a day, so the time an obstetrician-gynecologist is not on call causes the additional stress of having to secure coverage because we all know that babies come when their ready not when their mother's physician is available. I conclude by asking that the distinguished Members of this Committee remember that *there are two very human sides to the health care liability reform debate*—the very well-publicized plight of the victims—but also the much less discussed plight of health care providers too. I respectfully suggest that both are worthy of this distinguished panel's consideration.

CORWELL & MORING,
Washington, DC, June 14, 1994.

Hon. HOWELL HEFLIN,
U.S. Senate,
Committee on the Judiciary,
Washington, DC.

DEAR SENATOR HEFLIN: Thank you for your letter of May 31 and your very kind words about my May 24, 1994, testimony before your Subcommittee on Courts and Administrative Practices about medical malpractice and health care liability. As you appreciated, I tried to make an objective presentation.

By this letter, I am responding to questions sent to me by Senator Thurmond. My replies are enclosed.

Respectfully yours,

VICTOR E. SCHWARTZ.

ANSWERS TO QUESTIONS FROM SENATOR THURMOND TO VICTOR E. SCHWARTZ

Question 4. Could each of you on the panel please give your views on whether you think physicians and other providers will be less careful or act less competently if medical malpractice procedures are reformed? For example, if the expense resulting from a malpractice incident were to decrease from $500,000 to $100,000 would you expect medical providers to be less careful?

Answer 4. When limits have been placed on the amount of pain and suffering damages, *i.e.,* in California and Indiana, there apparently is no evidence that there has been an increase in the number of incidents of medical malpractice. A physician's primary focus is on doing his or her job with care; if he does not, it affects his or her reputation in an adverse way. For some person who may not appreciate their own carelessness, adequate oversight may be necessary, but this oversight is best found through adequate reporting of incidents and appropriate review by regulatory authorities.

Question 6. If periodic payments over a period of years or decades are to be made to a victim of malpractice, should the defendant be allowed to make the payments as they come due or should an annuity or other financial device be required to protect against the defendant becoming insolvent?

Answer 6. For a periodic payment system to work appropriately, payments should derive from an annuity or other financial device that would help assure that payments will be available as they become due. The vicissitudes of litigation and of business can result in a defendant being unable to pay in the future; a claimant should be protected against such adverse consequences and that is a fundamental reason why an annuity should be used when the periodic payment approach is adopted.

Question 7. If limits on attorneys' fees are imposed, should there be a different limitation on cases which are settled compared to those which are fully litigated? What flexibility in fee limits would you recommend?

Answer 7. In my experience in doing work on behalf of plaintiffs, my fees and others were less when cases were settled than when they were fully litigated. A general range for settled cases is between 20 and 25 percent and for litigating cases between 33 and 40 percent.

If fee limitations are used in legislation, flexibility should be provided for situations where an extraordinary number of hours was spent by plaintiffs' counsel in resolving a difficult case. Similarly, flexibility should be provided for cases that are relatively certain to win and easy to resolve, i.e., when foreign objects are left in abdominal cavities following an operation. In order to achieve flexibility, it is essential for claimants' attorneys to have adequate records of how many hours they spent and what they did in relation to their fee. It is also important for estimates to be given by the claimant's attorney to his client in the beginning of the case regarding the chances for success and time and effort it would take to reach a successful result.

Fixed limits on attorneys' fees can be as arbitrary as fixed limits on the sales of any goods and services. They need to be adapted to the value of the service. If this approach is taken, it will be fair to both the attorney and his or her client.

Question 8. Could each of you please state your views on whether it would be permissible for medical providers and patients prior to treatment to enter into agreements to use binding arbitration procedures for any malpractice claims that may result from the treatment?

Answer 8. In general, I think it is permissible for medical providers and patients, prior to treatment to enter into agreements to use binding arbitration procedures

for any medical malpractice claims that may result from treatment. The agreements should be entered into on a consensual basis by both sides. It would be inappropriate if the entire medical community used such agreements and would only treat patients if they entered into them—then the agreements would not be voluntary. But, if the agreement is entered into on a voluntary basis on both sides, it may result in a substantial savings in legal costs, more accurate determination of results, and facilitate or expedite reaching a sound and fair result.

Question 9. On several issues, some of you indicated in your written testimony that no action should be taken by the Congress until more experience is developed by the States. To what extent do each of you think that medical malpractice or parts of the malpractice system should continue to be resolved under State law, as it has been traditionally?

Answer 9. In many ways, medical malpractice is an intra-state tort issue. Generally, the preponderance of facts dealing with a particular medical malpractice incident occur within the borders of one state. In that regard, it can be contrasted with product liability where over 70 percent of the cases involve facts that occurred more than one (sometimes many) states.

Federal product liability law is, indeed, supported by the fact that events occur in interstate commerce.

Federal intervention in the medical malpractice area is supported by national goals that are to be achieved in general health care reform. These goals include eliminating unnecessary costs spawned by litigation, expediting results, and assuring fairness to all parties. I believe that these goals can be achieved without supplanting state medical malpractice laws in their entirety. The areas where reform can best achieve federal goals include:

1. Elimination of the collateral source rule when the source was developed from funds other than the plaintiff. Where plaintiff's funds were used to pay premiums, the amount of the award should be reduced by his or her contributions into the system.
2. Reasonable guidelines for damages for pain and suffering that are fair and have adequate flexibility to reflect the seriousness of the injury.
3. Reasonable guidelines and limits on punitive damages, including fair rules that address the problem of the imposition of multiple punitive damages for the same or similar conduct.
4. A fair and balanced system providing for periodic payments in cases involving injuries above $100,000.
5. Appropriate disclosure rules with respect to attorneys fees.

It is essential that all rules apply to all parties in any way connected with a medical malpractice section. The focus should be on health care liability, not medical malpractice alone. If one does not follow that approach, all rules will simply result in shifting costs from one group of defendants, *i.e.,* health care providers to others, suppliers of raw materials, health maintenance organizations and product manufacturers.

I appreciate your interest in my answers to these questions.

AMERICAN BAR ASSOCIATION,
GOVERNMENTAL AFFAIRS OFFICE,
Washington, DC, June 21, 1994.

Hon. HOWELL HEFLIN,
Chairman, Subcommittee on Courts
and Administrative Practice,
Committee on the Judiciary,
U.S. Senate,
Washington, DC.

DEAR MR. CHAIRMAN: Thank you for the opportunity to testify before your Subcommittee on May 24, 1994 in my capacity as Chair of the American Bar Association Special Committee on Medical Professional Liability. I am writing to you, today, in response to your May 31, 1994 letter to me with questions on the subject of medical malpractice in health care reform. I appreciate the opportunity to answer your Subcommittee's inquiries.

Question 1. Mr. Corboy, you repeatedly refer in your written testimony to costs of less than one percent of all medical expenses as though they are insignificant. If it is possible to do so, do you not think it is worth saving *billions* of dollars every

year, even though that may only be a small part of the huge amount spent on health care?

Answer 1. I am always in favor of saving money. The increased use of voluntary ADR may save everyone money, and it may do so without adverse impact on the person injured by malpractice. Such proposals are positive. The same cannot be said for proposals such as caps on damages. Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation and thus help subsidize recoveries for less seriously injured persons who would be fully compensated. This would be grossly unjust and doubly so since doing so would not appreciably affect the cost of health care.

The bottom line should be whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public—injured persons—of full and adequate compensation from those responsible for their injuries. The question we need to ask is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those severely injured persons who are ultimately compensated. Very few people are the subject of such proposals. Any savings in the cost of health care would be a small fraction of that less than one percent figure. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are injured by medical malpractice.

Question 2. Mr. Corboy, as I understand proposals to modify the collateral source rule, they generally would prevent the plaintiff from obtaining a double recovery from both the defendant and another source, such as an insurer. If this is correct, on what basis do you state in your written testimony that eliminating the collateral source rule will not reduce health care costs?

Answer 2. Proposals to deduct the value of a potential collateral source from an award often have the negative effect of shifting the obligation to pay from the medical provider's insurer to another health care provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical or other costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover its payments from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, as in the case of medicare, government health care costs would increase. The end result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of other health care providers.

Question 3. Mr. Corboy, what is your response to claims that tort reform in California is responsible for reducing malpractice premiums between 1976 and 1991?

Answer 3. Changes in the tort law may possibly have reduced malpractice premiums in California. Nonetheless, there is no evidence that if premiums have been reduced, such reductions in premiums have had any impact on overall health care costs in California. Changes in the tort laws such as caps on damages do, however, have a detrimental impact on those most severely injured by medical malpractice. As your witness, Cynthia Lebow of the Department of Justice said:

> * * * studies have shown and it is obvious that those affected by caps on damages are those claimants who have been most severely injured. It is those individuals who need the money the most to compensate for the losses they have suffered and to get on with their lives with some degree of dignity and hope. No one wants to tell persons who have been severely injured through the negligence of others that they will not get fair compensation because there is some arbitrary limit, and that they are simply out of luck.

It is often asserted that caps on noneconomic damages and elimination of the collateral source rule result in lower medical malpractice costs and this may be so. In general, these types of proposals have been enacted only within the last twelve years. Insufficient time has elapsed, and insufficient data has been gathered to en-

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able us to be certain of the impact on costs of these proposals. However, from our research and study it appears that these proposals have not had any measurable impact on overall health costs. In looking into the issue we found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. Pages 5 and 6 of my written statement elaborate on our research.

Question 4. Could each of you on the panel please give your views on whether you think physicians and other providers will be less careful or act less competently if medical malpractice procedures are reformed? For example, if the expense resulting from a malpractice incident were to decrease from $500,000 to $100,000 would you expect medical providers to be less careful?

Answer 4. I have no reason to believe that the proposed changes in the law now being considered by your Subcommittee would cause doctors to change there practices in any way.

Question 6. Mr. Schwartz and Mr. Corboy, if periodic payments over a period of years or decades are to be made to a victim of malpractice, should the defendant be allowed to make the payments as they come due or should an annuity or other financial device be required to protect against the defendant becoming insolvent?

Answer 6. There should definitely be an annuity or other financial devise required to protect against the defendant becoming insolvent. There are potential benefits of periodic payments where the settlement is voluntary and terms and conditions can be tailored to suit the needs and desires of both parties. First, the injured party can secure an arrangement of payments to coincide with the timing of that party's needs during his expected life span. Second, the defendant may be able to achieve a settlement that will require a smaller immediate and, possibly, smaller total, cash outlay than a lump-sum total payment if the plaintiff should reach his anticipated life expectancy.

However, serious practical obstacles are present where a court or legislature mandates that structured or periodic payments be made in all cases reaching an itemized verdict and judgment or in cases where the judgment exceeds a certain amount. The reason is that a myriad of considerations will dramatically vary from case to case. For example, an initial decision would have to be made concerning a monetary amount beyond which such payments would be mandated. It would be obviously impractical to apply this rule to all cases, requiring the courts to monitor the periodic payments as they do in some domestic and trusts and estates cases. At the same time, setting the threshold amount too high would render the rule applicable to so few cases that the impact on the system would be negligible.

A second decision would have to be made concerning whether all future damages would be subject to periodic payments. If they are not, some types of damages, such as noneconomic, future lost earnings or loss of earning capacity and future medical expenses, must be differentiated in order to specify which damages would be subject to periodic payments.

An additional question is whether it is fair to reduce to present money value any future losses for which present lump-sum payments would not be made. If future medical expenses are substantial and not reduced to present money value, the award for damages would be greatly increased.

Other important questions are raised as well, such as whether a periodic payment plan should permit variations in awards according to changes in extrinsic circumstances, such as inflation rates or changes in the physical condition of the plaintiff.

Question 8. Could each of you please state your views on whether it would be permissible for medical providers and patients prior to treatment to enter into agreements to use binding arbitration procedures for any malpractice claims that may result from the treatment?

Answer 8. The ABA supports the voluntary use of arbitration for resolution of medical malpractice disputes so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and so long as the agreement to arbitrate is entered into only after a dispute has arisen.

Question 9. On several issues, some of you indicated in your written testimony that no action should be taken by the Congress until more experience is developed by the States. To what extent do each of you think that medical malpractice or parts of the malpractice system should continue to be resolved under State law, as it has been traditionally?

Answer 9. The ABA believes that the regulation of medical professional liability is a matter for state regulation and that federal involvement in the area is inappropriate.

Again, I was glad to answer the questions posed in your letter. Please do not hesitate to call me should you have further inquiries. I can be reached at 312–346–9131,

Sincerely,

PHILIP H. CORBOY,
Chair, ABA Special Committee
on Medical Professional Liability.

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